An Analysis and Evaluation of Certificate of Need Regulation in Maryland

Working Paper: Nursing Home Services

MARYLAND HEALTH CARE COMMISSION

Division of Health Resources
4201 Patterson Avenue
Baltimore, Maryland 21215
www.mhcc.state.md.us

October 25, 2000

Donald E. Wilson, M.D., MACP
Chairman

John M. Colmers
Executive Director

Table of Contents

APPENDICES

I. INTRODUCTION

A. *Purpose of the Working Paper*

Through House Bill 995[1], the Maryland General Assembly has required that the Maryland Health Care Commission ("MHCC" or the "Commission") examine the major policy issues of the Certificate of Need ("CON") process. This is one in a series of working papers which the Commission will be releasing in 2000 and 2001, which will examine specific issues and implications of changes to the CON model of regulation. The purpose of this report is to examine the current CON policy and regulatory issues affecting nursing home services in Maryland, and to outline several alternative options for changes to the Certificate of Need program and their potential implications. Nursing home services is one of the services defined in health planning statute (Health General, Article 19-123(a)) that requires a Certificate of Need to establish, and in some cases, to expand.

B. *Invitation for Public Comment*

The Commission invites all interested organizations and individuals to submit comments on the options presented in this working paper. Written comments should be submitted no later than close of business ***Monday, November 20, 2000*** to:

Barbara G. McLean, Acting Executive Director
Maryland Health Care Commission
4201 Patterson Avenue; 5th Floor
Baltimore, Maryland 21215-2299
Fax: 410-358-1311
Email: bmclean@mhcc.state.md.us

C. *Organization of the Working Paper*

This paper is organized in five major sections. Following this introduction, Part II of the paper contains an overview of nursing home services, including a definition of the services, an inventory of existing providers, and data on utilization trends. This section of the paper also discusses alternatives to and the future of nursing homes, reimbursement issues facing nursing homes, quality of care issues, access to care, cost efficiency of nursing homes, and nursing home bed need projections and State Health Plan standards. Part III compares Maryland Certificate of Need regulation to what other states are doing with regard to regulating nursing homes. Part IV describes the functions of the state government agencies with an interest related to their authority over activities in nursing homes. Part V of the paper outlines alternative regulatory strategies for the Certificate of Need program that reflect different assumptions about the role of government regulatory

[1] Chapter 702, Acts of 1999.

agencies and the role of the market place in protecting the public interest. The appendices to the working paper include a series of detailed data tables on nursing homes, a listing of licensed nursing homes, a listing of assisted living facilities, and the nursing home bed need methodology.

II. MARYLAND NURSING HOMES: OVERVIEW

A. Definition of Nursing Homes

For health planning purposes, a nursing home is defined as a facility licensed in accordance with COMAR 10.07.02 that admits patients suffering from diseases, disabilities, or advanced age who require medical service and nursing service rendered by or under the supervision of a registered nurse.

As of October 1, 2000, Maryland had 275 nursing homes facilities (including other facilities or units with comprehensive care beds) with 31,004 licensed and operating beds. In addition, there were: 484 beds that are CON-approved but not yet licensed, and a total of 1,707 temporarily delicensed beds being maintained on the Commission's inventory. There were a combined total of 32,682 beds in Maryland's nursing home bed inventory as of October 1, 2000.[2]

Operating nursing home beds are those beds which have received and hold a "comprehensive care facility" (nursing home) license from the Office of Health Care Quality under COMAR 10.07.02. Such facilities have either received a Certificate of Need, or been grandfathered with successive changes to the health planning statute. Temporarily delicensed beds are those beds granted permission by the Commission to be taken off the license and out of service, pending plans to delicense or otherwise use the beds. To clarify its regulatory practice with regard to off-line capacity, the Commission has proposed regulations that establish conditions under which facilities may temporarily remove beds from their license, or close an entire facility on a temporary basis.

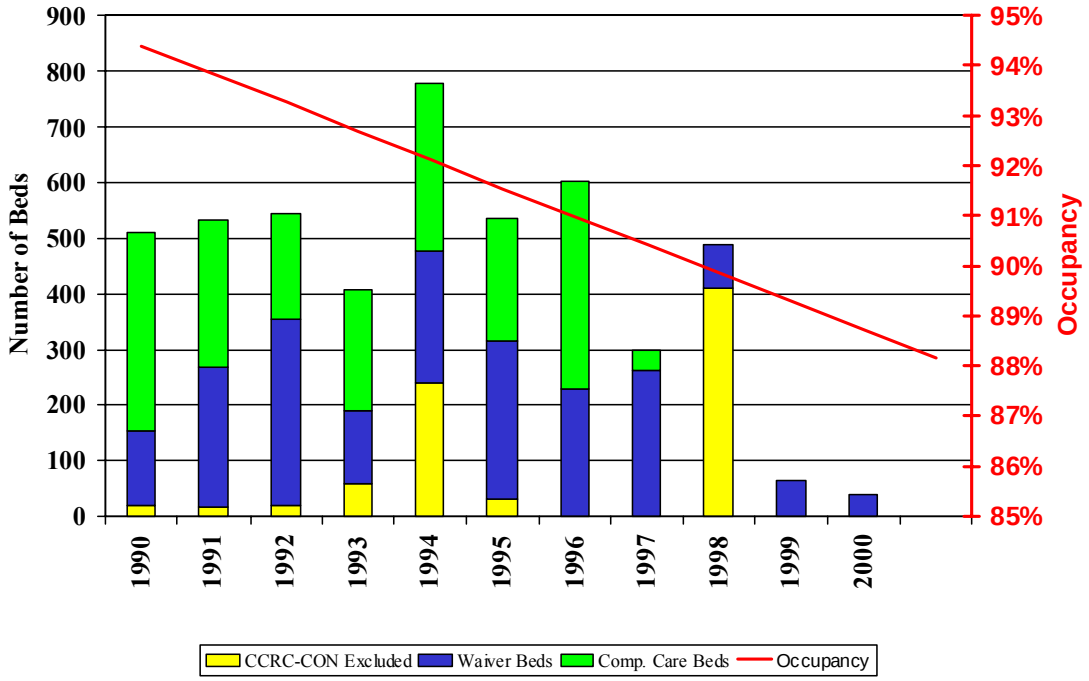
CON-approved beds have received a Certificate of Need from the Commission (or its predecessor agency, the Maryland Health Resources Planning Commission) by meeting all of the appropriate standards under COMAR 10.24.08 (the State Health Plan chapter that addresses long term care services) as well as the general criteria applied to all Certificate of Need reviews at COMAR 10.24.01.08. Waiver beds are those beds approved under COMAR 10.24.01.02(A)(2)a., generally involving a change in capacity of 10 beds, or 10 percent, whichever is less. Table 2 below illustrates the number of the nursing home beds that have been approved between fiscal years 1990 and 2000, and the means by which each portion of the year's total was approved:

- CON-approved bed need projected by the State Health Plan;
- Waiver beds; or
- CON-excluded beds at continuing care retirement communities.

The line traveling from the upper left of the chart to the lower right illustrates the drop in overall nursing home occupancy during the same period.

[2] See Appendix C for an inventory of comprehensive care beds by county and health service area.

Figure 1
Nursing Home Beds Approved in Maryland: 1990 - 2000



The types of beds licensed as comprehensive care facility, or nursing home, beds can be found at other kinds of facilities, as so-called "subacute" units in hospitals (or in separate units in regular nursing facilities) and within continuing care retirement communities, or CCRCs.

Subacute care is not a licensure category; such care can be provided in hospitals or nursing homes. Subacute care beds may be licensed as special care (COMAR 10.07.02.14-1, 14.2) Subacute refers to care defined under COMAR 10.24.05 as follows:

- Subacute care means comprehensive inpatient care that is designed for someone who has had an acute illness, injury, or exacerbation of a disease process whose treatment does not require to any significant degree, high technology monitoring or complex diagnostic procedures, and which has the following characteristics:

- It is goal-oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex conditions or to administer one or more technically-complex treatments in the context of a person's underlying long-term conditions and overall situation;

- It requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines, who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures;

- It is given as part of a specifically-defined program within a dedicated unit, regardless of site;

- It is generally more intensive than traditional comprehensive facility [nursing home] care and less intensive than acute care;

- It requires daily to weekly recurrent patient assessment and review of the clinical course and treatment plan for a limited period of several days to several months, until the patient's condition is stabilized or a predetermined treatment course is completed[3]; and

- Requires certification from the Office of Health Care Quality as a provider of special care in accordance with COMAR 10.07.02.14.1-14.2.

Continuing Care Retirement Communities ("CCRCs") are communities, usually including independent living units, assisted living units, and nursing homes, regulated by the Maryland Department of Aging under Article 70B and COMAR 14.11.02. To distinguish such communities from senior housing complexes and other types of living arrangements for seniors, the Maryland Department of Aging ("MDoA") requires a community to meet the following criteria for certification as a CCRC:

- Its subscribers pay an entrance fee that is, at a minimum, three times the weighted average of the monthly service fees;

- Subscribers sign a contract for a period of more than one year, usually for life, that requires either a transfer of assets or payment of an entrance fee and monthly fees to live in a secure and protected environment; and

- The community provides, at a minimum, access to medical and nursing services or other health-related benefits.

The nursing home beds in CCRCs are also regulated under the Commission's Certificate of Need program (COMAR 10.24.01) and under planning regulations (COMAR 10.24.08). If a CCRC applies for, and successfully obtains, a CON for nursing home beds, it can serve both its own enrolled residents as well as the general public. However, CCRCs can also obtain nursing home beds through a CON exclusion under COMAR 10.24.01 B(11)(b)(ii). To qualify for this exclusion, a CCRC must satisfy three

[3] Weiss, Cathy and Rebecca Rosenstein, Ph.D., Subacute Care Project: Preliminary Report. December, 1995.

criteria, two of which have been altered by legislation enacted during the 2000 legislative session.

- Beds obtained through this exemption must not exceed the ratio of one bed for every five independent living units (or 20 percent). This year's legislation raises that ratio to 24 percent for those communities with fewer than 300 independent living units.

- The CCRC must serve exclusively its own residents in the nursing home beds; it cannot market directly to the general public. This was modified in 1999 to permit the admission of two spouses (or two persons having a long-term significant relationship) to a CCRC, where one is admitted to an independent or assisted living unit and one is admitted directly into a nursing home bed. The 2000 statutory changes provide for "limited direct admission" of persons directly into a nursing home bed who have a reasonable likelihood of eventual transfer to an independent or assisted living unit. These admissions cannot exceed 20 percent of the CCRC's nursing home beds and cannot cause occupancy to exceed 95 percent.[4]

- It must provide nursing home care on the same campus as the independent living units.[5]

B. Supply and Distribution of Nursing Homes in Maryland

In order to have some perspective on the changes in Maryland's nursing home bed capacity, it is useful to look at the changes in that bed capacity from 1990 to 2000.

Table 1
Changes in Nursing Home Bed Capacity: Maryland, 1990-2000

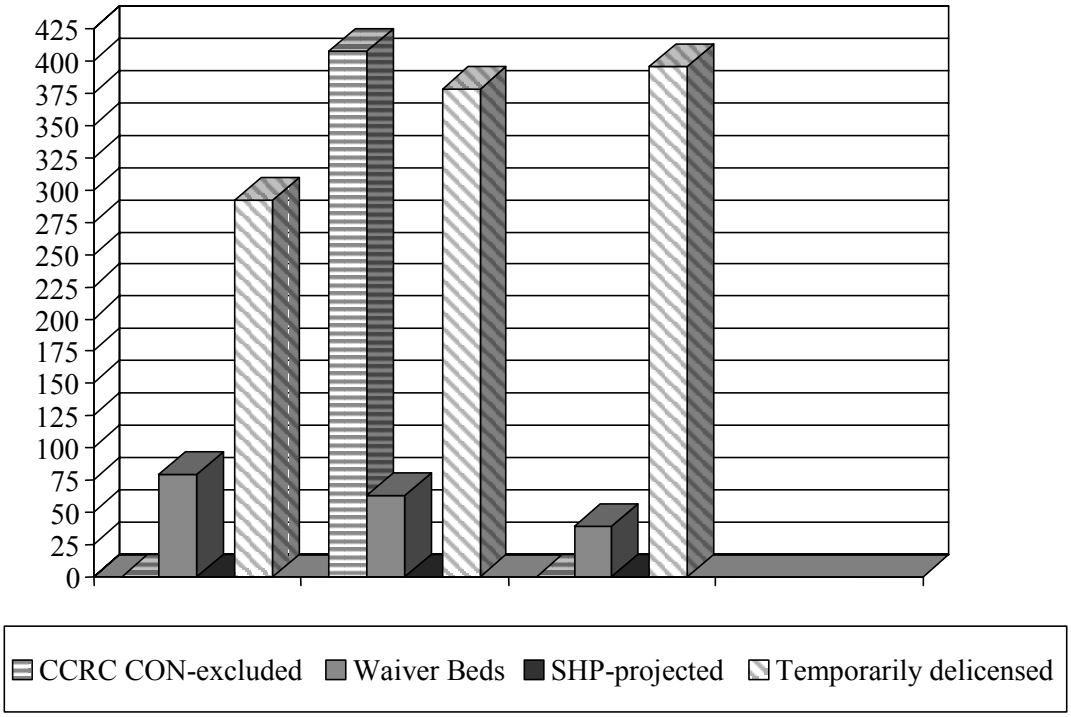
Year	Licensed Beds	CON-Approved Beds	Waiver Beds	Total Beds
1990	26,894	2,626	504	30,024
2000	31,505*	511	578	32,594
CHANGE '90-'00	+4,611	-2,115	+74	+2,570

Source: Maryland Health Care Commission, Inventory of Comprehensive Care Beds, July 2000 (unpublished) and Commission inventories 1990.
* Note: the bed count for 2000 includes both licensed as well as temporarily delicensed beds.

[4] These changes were made during the 2000 legislative session with regulations which were released for public comment at the September 15, 2000 Commission meeting.
[5] Continuing Care Retirement Communities: An Examination of Policies Governing the Exemption of Nursing Home Beds from Certificate of Need Review. Final Report. February, 1999.

While the number of licensed beds has increased, as discussed below, the rate of increase of licensed beds has slowed. Also, it should be noted, the count of 32,682 nursing home beds included 1,707 temporarily delicensed beds (plus another 684 beds from now-closed facilities acquired for re-development), which, in accordance with proposed regulations, will either be brought on line, or removed from the inventory.

Figure 2
Nursing Home Beds Approved FY 97-FY00,
with Beds Temporarily Delicensed



The number of certified but unbuilt beds has decreased, because the Commission has withdrawn the Certificate of Need approvals for several large projects that were not implemented within prescribed time limits, even with numerous extensions[6]. The number of waiver beds has increased slightly, but these are beds that fall into the category of 10 beds or 10 percent (whichever is lower) which facilities can request without having to undergo a full CON review. Per COMAR 10.24.08.05L(2) and (3), waiver beds cannot be banked, or more beds cannot be obtained until these beds become licensed and operational.

[6] Village Care Nursing Center, Willow Brook Nursing and Rehabilitation Center; Upper Marlboro Nursing and Rehabilitation Center relinquished its Certificate of Need in a withdrawal proceeding.

C. Trends in the Utilization of Maryland's Nursing Home Services

In order to place the nursing home industry in context, it is necessary to examine the target population of nursing homes. Although nursing homes serve persons of all ages, about 90 percent of those residing in nursing homes are 65 and over. Therefore, the focus of this section will be those individuals in Maryland's population aged 65 and older.

Nationally, it is well documented that the population is aging, due in large part to the aging of the large Baby Boom Generation, i.e. those born between 1946 and 1964. For example, in 1900, the 65 and older population nationally represented 4.1 percent of the total population. By 2040, it is estimated that the 65 and over age group in the U.S. will be 20.3 percent of the total population. Similarly in Maryland, the 65 and older population represents 11 percent of the total population in 2000. This is expected to rise to 16 percent in 2020.[7]

The development of an older population is due not only to the growing ranks of Baby Boomers, but also to the extension in life expectancy. A child born in 1997 could expect to live to 76.5 years, about 29 years longer than a child born in 1900. This is due primarily to reduced death rates for children and young adults. Life expectancy at age 65 increased by only 2.4 years between 1900 and 1960, but has increased by 3.3 years since 1960.[8]

Income for the elderly has also improved. Income for households headed by persons 65+ was reported at a median income nationally of $31,568 in 1998. Maryland residents fare better than the national average. For all ages, the median income per household in Maryland in 1998 was $50,016 compared to $38,233 nationally. In terms of the 65+ population, 8.9 percent were below the federal poverty limit in Maryland as compared to 10.6 percent for the U.S.[9]

With increasing age come increasing levels of disability. In 1990-1991, 9 percent of persons aged 65-69 needed assistance with everyday activities as compared to 50 percent of those 85 years and over.[10] However, recent research findings indicate that previous levels of disability may actually be declining. According to analyses from the National Long-Term Care surveys, the percentage of both institutional and community-based persons aged 65+ who were disabled declined between 1982 and 1994. For those persons in the community, the percentage disabled dropped from 18.0 percent in 1982 to 16.0 percent in 1994. For those individuals in institutions, the proportion declined from 5.7 percent to 5.1 percent for the same period. From 1982 to 1994, the proportion of the population 65+ who were not disabled rose from 76.3 percent to 78.9 percent. This

[7] Maryland Office of Planning, Population Projections, June 1999 revisions.
[8] Administration on Aging, Profile of Older Americans: 1999. Website:http//www.aoa.dhhs.gov/aoa
[9] Ibid. and U.S. Bureau of the Census. Current Population Reports, p. 60-206. Money Income in the U.S. 1998
[10] U.S. Census Bureau. Sixty-Five Plus in the United States, May 1, 1995.

finding, of a drop in disability levels among the most elderly, is remarkably consistent across several recent studies.[11]

D. Alternatives to Nursing Home Care

1. Public Image of Nursing Homes

In addition to the challenges of financial uncertainties and quality concerns, nursing homes continue to face a public relations problem. In public opinion polls, many Americans say that they will go "anywhere but a nursing home." The American Health Care Association (AHCA), recognizing this issue, launched an initiative called "SecureCare" in 1997. While aimed at finance reform, it also tried to address the public relations problems in America's nursing homes. Again for the Year 2000, an area of concentration identified by AHCA is "the generation of positive news stories".[12] At a local level, the Mid-Atlantic Non-Profit Health and Housing Association announced in its June 2000 newsletter that it wants to emphasize the positive in a new section entitled "Beyond the Call of Duty"; its purpose is to "be a step in countering the negative publicity that providers have endured from the mainstream press."[13]

When nursing homes first emerged in the 1960s, they were viewed by some as "places to die". As the nursing home industry developed more of a medical model, and as hospitals discharged patients "sicker and quicker", nursing homes were able to develop more consumer confidence as they approached being "mini hospitals". If former HCFA Commissioner Bruce Vladek's opinion is any indication, nursing homes have a long way to go to improve their image: "[nursing home] residents live out the last of their days in an enclosed society without privacy, dignity, or pleasure, subsisting on minimally palatable diets, multiple sedatives, and large doses of television---eventually dying, one suspects at least partially of boredom."[14]

Alan Solomont, former Finance Chairman of the Democratic National Committee ("DNC") and Co-Chair and Co-Chief Executive Officer of Solomont Bailis Ventures, predicts: "long term care is not going to shrink, but it isn't going to grow at the same rate at which it did in the mid 90s." He foresees an industry shakedown over the next year or so as providers shed debt accumulated during their expansion phase and compensate for decreased Medicare revenue growth. "The industry is going to move back a few steps and once again focus on its core Medicaid business."[15]

In the past, nursing homes had become the focus of the long-term care industry. Now, with a tremendous growth of home health, development of adult day care, and proliferation of assisted living, consumers have a wide range of alternatives from which to choose. "Growth in spending for nursing home care decelerated steadily from 13.3

---

[11] Liu, Korbin, Kenneth G. Manton, Cynthia Aragon. Changes in Home Care Use by Older People with Disabilities: 1982-1994. AARP Public Policy Institute, January, 2000.
[12] HFAM, Networks, February 2000, Volume III, Issue 1.
[13] MANPHA Monthly Mail, Vol. 7., No. 5, June, 2000.
[14] Bodenheimer, Thomas, op. cit., p. 1324.
[15] Childs, Nathan, op. cit., p. 43.

percent in 1990 to 3.7 percent in 1998, matching the slowest previous growth record in 1961. Much of the deceleration in growth since 1990 was the result of slowing growth in medical price increases and expanded use of alternative treatment settings such as home health care, assisted living facilities, and community-based day care."[16]

2. Home Health Care Services

The Medicare home health program was started in 1965 as a humane concept of providing care for persons in their home and aiding recovery in a familiar environment. There were many reasons for an interest in home care including: "reducing the financial burden of Medicaid nursing home spending on federal and state governments, the impoverishing consequences of the use of nursing homes by older people with disabilities, and the general preference of older people for home care." [17]The concept was popular, and, based on the ready availability of Medicare funding, the growth of home health services has been phenomenal. However, there is now serious concern with the rate of growth and its effects on Medicare spending nationally. Home health care reimbursements have grown by 300 percent nationally in the past six years alone.[18]

The rapid growth of home health care and its impact on the Medicare budget made the industry a focus of federal investigation. In 1995, a comprehensive anti-fraud initiative, Operation Restore Trust, was initiated. During this time, the Department of Health and Human Services' Inspector General and the General Accounting Office conducted investigations of certain states' home health agencies, finding various instances of inappropriate payment and cases of fraudulent behavior. In response to this, one focus of the Balanced Budget Act ("BBA") was on the home health program with the intention to slow the rate of expenditure growth, provide incentives for efficiency in the delivery of care, and ensure that Medicare pays appropriately for services.[19]

Questions have been raised on the degree to which home health substitutes for nursing home care. To the extent that nursing homes provide long-term custodial care, home health probably does not substitute. However, as nursing homes increasingly serve more short-stay, post-acute and subacute patients discharged from hospitals, there is probably more overlap in their populations. For more information on regulation of Home Health Services, see the Maryland Health Care Commission's *An Analysis and Evaluation of Certificate of Need Regulation in Maryland, Working Paper: Home Health Agency Services*, September 15, 2000.

3. Assisted Living

A study by Christine Bishop notes that an increasing number of nursing home residents are moving into alternative placements, such as assisted living, and she sees

[16] Levit, Katherine, et. al. "Health Spending in 1998: Signals of Change", Health Affairs 19(1):1124-1342.
[17] Liu, Korbin et. al., "Changes in Home Care Use by Older People with Disabilities: 1982-1994", Public Policy Institute, AARP, January, 2000.
[18] Havemann, Judith. "Fraud is Rife in Home Care for the Elderly". Washington Post, April 29,1997.
[19] MHCC, Maryland Home Health Agency Statistical Profile: FY 1998 and Trend Analysis: FY 1996-1998, June, 2000.

these trends continuing. Some of the shift is due to the falling prevalence of disability. However, a greater influence is the preference for less institutional placement. This has resulted in lower utilization rates for nursing homes. Comparing data from the National Nursing Home Surveys, Bishop found that the percent of Americans 65 and older, who lived in nursing homes, fell from 4.6 percent in 1985 to 4.2 percent in 1995. [20] For Maryland, using more recent data, the percentage of the population aged 65 and over, who were residents of nursing homes fell from 4.14 percent in 1990 to 3.78 percent in 1997.[21]

Assisted living is also a growth industry. It is difficult to get an exact count of assisted living facilities since there is no single definition that is applied consistently nationwide. Regulations and licensure vary by state, and such facilities are often classified as domiciliary care, residential care, or personal care, etc. The Assisted Living Federation of America estimates that there were 362,014 assisted living beds in 1991, compared to 777,801 in 1999, a growth rate of over 114 percent.[22]

In Maryland, Dianne Dorlester, Executive Director of Maryland Assisted Living Association (MALA) estimates that there are currently 13,000 to 15,000 persons in 2,500 assisted living facilities in Maryland.[23] Previously in Maryland, there were many types of residential programs governed by different regulations under different state agencies. Programs previously licensed under the Department of Health and Mental Hygiene (domiciliary care), the Department of Human Resources (Project HOME), and the Office on Aging, now the Department of Aging, (sheltered housing) are now combined under the assisted living classification. Under regulations developed in July, 1998 in response to legislation passed in 1996, the Office of Health Care Quality now inspects and licenses all assisted living programs in Maryland. For an inventory of assisted living programs licensed by the Office of Health Care Quality, See Appendix D.

4. Medicaid Home and Community-Based Services Waiver for Older Adults

The Department of Health and Mental Hygiene and the Maryland Department of Aging ("MDoA") implemented the Senior Assisted Housing Waiver in 1993. In 1999, the Maryland General Assembly passed SB 593, which directed DHMH to expand the Senior Assisted Housing Waiver to cover services in all types of licensed assisted living facilities, as well as supportive services for individuals living at home. Under Medicaid rules, states can apply to the federal government to allow coverage of long term care in the community for certain populations through waivers. Without a waiver, only general nursing home service is covered.

---

[20] Assisted Living Executive Report, Vol, 4, No. 4, February 16, 2000.
[21] Maryland Health Care Commission long term care survey data. Data based on residents of nursing homes who were Maryland (excludes out of state) residents aged 65+ as a proportion of Maryland population aged 65+.
[22] "Too Much Too Soon Halts Assisted Living Boom", The New York Times, May 28, 2000.
[23] Lynch, Heather. "Assisted Living Facilities: a Fast-Growing Niche for Developers, Architects, Builders". Daily Record, February, 2000.

In an effort to enhance home and community-based services for older adults, on March 28, 2000, the federal Health Care Financing Administration ("HCFA") issued a partial approval for major expansion of Maryland's current Senior Assisted Housing Waiver to provide a package of 16 home and community-based services for qualified older adults (aged 50 and older) who need nursing home level of care, but live at home or in a licensed assisted living facility. The original waiver provided services to 135 older adults. In order to qualify, individuals had to receive services in Senior Assisted Housing group homes certified by MDoA, meet certain Medicaid financial requirements, be at least 62 years old, be eligible for MDoA housing subsidies and for Medicare, live in certain jurisdictions, and be medically qualified for nursing facility level of care under the Medicaid program.

The details of the proposed waiver expansion were developed by a workgroup that included representatives from other State and local agencies, advocacy organizations, providers, and provider organizations. HCFA denied the State's request to expand the waiver's medical eligibility to include individuals determined to be at risk for needing nursing facility services. The amended waiver, which has been renamed the Waiver for Older Adults, will cover 1,135 individuals in its first year and will expand to 5,135 individuals after five years, depending on budget appropriations.

Effective in July 2000, the existing waiver was expanded statewide and the number of slots was increased. At the same time, DHMH and MDoA began putting new operational systems and regulations in place for the expanded services. Beginning in the fall of 2000, the State of Maryland will have regional training sessions for potential providers of new waiver services, and in November 2000 it will begin to process applications for new providers to participate. The regulations will be effective on January 1, 2001. During the upcoming months, the MDoA will continue to develop its database of information on companies and individuals that are interested in enrolling as service providers for the Medicaid Waiver for Older Adults.

On January 1, 2001, the target population of individuals who are eligible for the Waiver for Older Adults will expand from those individuals at least 62 years of age to individuals at least 50 years of age. New services will become available and new provider types will be able to participate. Eligible participants will be able to receive services in their homes or in large or small assisted living facilities.

Administered by the local Area Agencies on Aging either directly or through contract with the local department of social services or local health department, the Waiver for Older Adults will target low income adults if they live at home or in a licensed assisted living facility and are:

- At least 50 years of age;
- Have a monthly income of no more than $1,536.00 (300% of the Supplemental Security Income level);
- Have assets that are no more than $2,000.00 to $2,500.00, depending on eligibility category; and

- Qualified for nursing facility level of care at the time of entry into the waiver, and reassessed at least every 12 months to need this level of care;
- Not enrolled at the same time in another Medicaid 1915(c) waiver, Program of All-Inclusive Care for the Elderly (PACE), Rare and Expensive Case Management (REM), or any future Medicaid capitated managed care program that includes long term care;
- Living in any jurisdiction within the State of Maryland;
- Freely choosing between waiver or nursing facility services.

The waiver program must be able to assure the individual's health and safety and meet the individual's needs in a community-based setting.

Regarding needs allowance and client contributions, effective 1/1/2001, an individual living at home will retain all of his/her income for personal and living expenses and will not pay towards the cost of waiver services. Further, an individual receiving the waiver's assisted living services may retain $60/month for personal needs and, at most, $420/month to pay the assisted living provider for room and board. The remainder of the individual's income must be paid to the assisted living provider for assisted living services.

Each waiver participant may cost Medicaid no more in the community than Medicaid's average costs for nursing facility residents over the course of a year. Moreover, a lien may not be placed on a waiver participant's home. However, the State of Maryland may recover from the estate of a person over 55 years of age, who does not have a surviving spouse, an amount no more than Medicaid's payments for that person.

Covered Waiver services include (new services are in bold print):

- **Personal care**
- **Respite care**
- Senior Center Plus[24]
- **Personal emergency response systems**
- **Extended home health care**
- **Environmental modifications** & assessments
- **Home-delivered meals**
- Assisted living services
- **Family/consumer training**
- **Dietitian/Nutritionist Services**
- **Assistive devices**
- Case management (Administrative service through Area Agencies on Aging)
- Behavior consultation services

Other services to be available under Medicaid include:

- Medicaid acute, primary, & preventive services

[24] Senior Center Plus, whose providers are certified by MdoA, is a structured day program in an out-of-home, outpatient setting; included are group recreational activities, supervised care, personal assistance, enhanced socialization, and at least one nutritional meal; Medicaid payment does not include transportation; services are less medical with different staffing requirements and lower reimbursement than Medicaid State Plan medical day care. Source: Specifications for Medicaid Home and Community-Based Services Waiver for Older Adults as Expansion of the Senior Assisted Housing Waiver Per Senate Bill 593 (September 15, 2000), page 3.

- Home health care
- Transportation (Through local health departments)
- Medical day care
- Durable medical equipment
- Disposable medical supplies

The following types of providers may be eligible to offer certain types of services in the Waiver for Older Adults, if they meet the waiver's requirements:

- Licensed assisted living programs
- Residential service agencies
- Meal delivery services
- Local Health Departments
- Local Departments of Social Services
- Congregate housing providers
- Personal emergency response vendors
- Senior Center Plus Centers
- Home health agencies
- Nursing facilities
- Medical day care centers
- Respite care providers
- Personal care providers
- Building contractors
- Certain types of licensed professionals (e.g. dieticians/nutritionists)
- Medical equipment vendors

All providers participating in the Waiver for Older Adults must be approved Medicaid providers and appropriately certified[25].

Each waiver participant receives a home visit and multidisciplinary assessment from the Adult Evaluation and Review Services ("AERS")(formerly Geriatric evaluation services) under the local health department. AERS completes an assessment which is reviewed and signed by a physician and submitted to the Delmarva Foundation for Medical Care (DHMH's contractual utilization control agent) to determine whether the individual needs nursing facility level of care. While Delmarva evaluates medical eligibility for the waiver, using the assessment tool (DHMH Form 3871), a Central Office waiver unit at the Department of Human Resources (rather than the local department of social services) determines financial and technical eligibility for Medicaid and the waiver, based on DHMH instructions.

An individual's waiver plan of care is developed by a team which includes at least the participant or legal representative, the waiver case manager, and the AERS social worker and nurse. The waiver plan of care preauthorizes waiver services, and assures that the individual costs Medicaid no more in the waiver annually than the individual would have cost Medicaid as a nursing facility resident. MDoA (or the area agency on aging if it is a public agency) approves an individual's waiver plan of care and any subsequent revisions. At least every three months, the waiver case manager makes a home visit and reviews the participant's waiver plan of care. At least every 12 months, the participant's waiver eligibility is redetermined. AERS reassesses the participant, and

[25] Medicaid Home and Community-Based Services Waiver for Older Adults, Fact Sheet, distributed by Maryland Medical Care Programs July 20, 2000

Delmarva re-evaluates medical eligibility. The waiver plan of care is reviewed by the multidisciplinary team and revised as necessary.[26]

With Medicaid funding for what is now largely a private pay service, it would be expected that use of these facilities would increase at an even faster rate. In the future, there will be a need to collect data and monitor the growth of assisted living in Maryland in order to monitor its impact on the long term care system. Regarding the Waiver for Older Adults, DHMH is developing specifications for computer programming changes to monitor the waiver's administration.

The development and increasing popularity of assisted living has made a significant impact on the financial stability of the nursing home industry. Though some of the decrease in utilization in nursing homes may be due to the falling prevalence of disability as well as changes in Medicare reimbursement, it is believed that shifts in utilization to other settings is a more important factor. Comparing National Nursing Home Survey data, the number of Americans 65 and older who lived in nursing homes fell from 4.6 percent in 1985 to 4.2 percent in 1995.[27] The current rates may be even lower.

5. Medicaid Home and Community Services Waiver for Adults with Physical Disabilities (Attendant Care Waiver)

Another service currently provided by Maryland's Medical Assistance Program is its Personal Care Program. This program reimburses for personal care services provided to chronically ill or disabled recipients who are under the care of a physician and require assistance at home with activities of daily living. The objectives of the program are to prevent patient deterioration, to delay institutionalization, and to prevent inappropriate institutionalization.

The Attendant Care Waiver, with its current working title: Living at Home: Maryland Community Choices, will be effective April 1, 2001. Its goal is to secure a more consumer-responsive Medical Assistance Personal Care Program, and to create a personal assistance system for Medical Assistance recipients that is responsive, flexible, offers quality services, and develops partnerships. The Attendant Care Waiver is currently capped at 400 participants, aged 21-59, with 150 participating in the first year, 300 in the second year, and 400 in the third year.

The philosophical foundation on which this particular waiver rests has two components. The first is one of self-determination. The Medical Assistance recipient has the right and responsibility to make his or her own decisions; to decide where he or she is going to live; to determine the utilization of resources under this waiver; and to participate fully and equally in the community. Secondly, this waiver is consumer –

[26] Specifications for Medicaid Home and Community-Based Services waiver for Older Adults as Expansion of the Senior Assisted Housing Waiver Per Senate Bill 593 (September 15, 2000), pages 1-2, 7.
[27] Bishop, Christine, cited in Assisted Living Executive Report, Vol 4, No. 4, February 16, 2000.

directed, i.e. the individual will make decisions regarding the type and the amount of assistance or services he or she receives.

The services available in the Living at Home: Maryland Community Choices to those 21-59 year olds who are residents of a nursing home, or are at risk for entry into a nursing home, will include the following:

- Attendant Care Services
- Case Management
- Assistive Technology
- Consumer Training
- Durable Medical Equipment /Supplies
- Environmental Accessibility Adaptations
- Family-Training
- Skilled Nursing Supervision of Attendants
- Occupational Therapy
- Personal Emergency Response Systems
- Speech/Language Services
- Transportation

Provision of these services could have a significant impact on the utilization of nursing homes, and therefore on the nursing home bed need projections.

Under this waiver, the participant will be able to use either one of two attendant care service models: agency-employed or consumer-employed, to secure services. To be eligible for the waiver, the participant's cost of care should be equal to or less than the participant's cost of care in a nursing home. Additionally, the waiver will have available State funding for services including a security deposit for a waiver participant's apartment, the purchase of household items, transportation, respite, mental health services, and heavy chore services. Non-Waiver Services not included in computing the waiver cost of care are those for Administration, Case Management, and the Fiscal Intermediary. Administration of the waiver will be under the auspices of the Department of Human Resources' Office of Personal Assistance Services, Case Management will be done regionally by local health departments, and the Fiscal Intermediary functions will also be done on a regional basis. Case Management functions will include assessment, planning, and enrollment coordination; ongoing case management such as service coordination and monitoring; and reassessments. Fiscal Intermediary functions will include payment processing, fiscal accounting, and reporting.

The impetus for the State of Maryland's action in moving forward with this waiver was the July 1999 Supreme Court decision, *Olmstead v. L.C.* The Court's decision in that case clearly challenges federal, state, and local governments to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective, community-based services. The *Olmstead* decision interpreted Title II of the Americans with Disabilities Act ("ADA") and its implementing regulation, requiring states to administer their services, programs, and activities "in the most integrated setting

appropriate to the needs of qualified individuals with disabilities." Medicaid and the waiver process can be important resources to assist the State in meeting these goals.[28] Communications from the U.S. Department of Health and Human Services ("HHS") to state governments leave no doubt that the federal agency, of which the Health Care Financing Administration, which administers the Medicaid Program, is a part, is interpreting *Olmstead v. L.C.* as covering any individual with a disability who lives in an institution, including a nursing home.[29] The Attendant Care Waiver is a means for the State to create a plan to find the least restrictive environment for disabled individuals whether they are in nursing homes or are at risk for entering nursing homes.

Because of the impact of the array of alternatives, many nursing homes have recognized that they must broaden their services for a chance to survive in the future. Many are branching out into other types of care in order to continue in operation, be financially viable, and to meet the needs and demands of a growing number of sophisticated, elderly who want more alternative services. The extent to which nursing homes are attempting to meet those requirements is shown by a survey conducted in 1997 by the American Health Care Association (AHCA) which found that its members offered several alternative services as follows: contract rehabilitation (26.5 percent); assisted living (21.7 percent); subacute (12.7 percent); adult day care (5.4 percent) home care (3.0 percent).[30]

For many years, nursing homes have had to face increasing competition from other models of care. These models, too, are now becoming more prevalent and more widely accepted. A few examples will be reviewed here: continuing care retirement communities (CCRCs); the Program of All-Inclusive Care for the Elderly (PACE); and Social Health Maintenance Organizations (S/HMOs).

6. Continuing Care Retirement Communities

Continuing care retirement communities as a model have existed in Maryland since the 1970s. CCRCs have grown from 14 in 1980 to 30 today (a growth rate of 114 percent). Now, twelve counties in Maryland are served by CCRCs, with a total of 2,350 nursing home beds. One of the appeals of CCRCs is that they offer an insurance model; that is, at least for the original type of CCRC model, a subscriber pays an entrance fee and monthly fees that cover all long term care services in exchange for a promise to provide a full range of care. The early CCRCs involved a transfer of assets. Many were church-sponsored and a prospective resident would have to give up his or her assets in exchange for lifetime care. The model then changed to continuing care, where a person paid an entrance fee and monthly fees and was guaranteed a full range of social, personal, nursing, and medical services, including nursing home care when needed. In order to

[28]Health Care Financing Administration website ,www.hcfa.gov/medicaid/olmstead/olmshome.htm, August 29, 2000

[29] The Supreme Court cautioned, however, that "nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings." HFAM Networks, July/august 2000, p. 8.

[30] HCIA and Arthur Andersen, The Guide to the Nursing Home Industry, 1998, p. x.

keep prices more competitive, many CCRCs offer an "a la carte" model where the person pays an entrance fee, but pays lower monthly fees for lower levels of care. Thus, a person can pay for an independent living unit for many years before experiencing an increase in fees for assisted living, nursing home, or other special services.

Although CCRCs were always potentially competing with nursing homes for the same patient pool, especially those with the financial resources to privately pay, for the most part, the two groups had distinct roles. Mainly, nursing homes provided "traditional" custodial care or post acute care, while CCRCs provided housing with some health services. CCRCs need to receive both certification from the Department of Aging, and their nursing home beds must be approved by MHCC in one of two ways. First, a CCRC could obtain a CON, in which case it could serve the general public in those particular nursing home beds without restriction, the same as any other nursing home. Second, a CCRC can obtain an exclusion from CON review, which permits it to establish a prescribed number of comprehensive care beds, and serve only its own residents who have signed contracts to live in independent and assisted living units in that particular CCRC community.

Recent legislation, passed during the 2000 legislative session, modified the CON statute as it applies to CCRCs. First, SB 403 modified the number of CON-excluded nursing home beds that a community may obtain. Under this new legislation, a CCRC with fewer than 300 independent living units would be able to obtain nursing home beds at 24 percent of the number of independent living units[31]; for communities with more than 300 independent living units, the 20 percent figure remains unchanged. This bill became effective October 1, 2000.

In addition, SB 146 permits limited direct admission of persons from the general community into nursing home beds at CCRCs under the following circumstances:

1. The entrance fees paid prior to entering the community must be at least equal to the lowest entrance fee charged for an independent living unit or an assisted living unit.

2. The CCRC may admit a subscriber directly into a comprehensive care bed only if, at the time of admission, the subscriber has the potential for an eventual transfer to an independent living unit or an assisted living unit. This must be determined by the subscriber's personal physician, who is not an owner or employee of the CCRC.

3. The total number of comprehensive care beds occupied by subscribers who have been directly admitted from the general public may not exceed 20 percent of the total number of comprehensive care beds at that CCRC.

4. The CCRC must not admit a subscriber directly from the general community into a comprehensive care bed if that admission would cause the occupancy of the comprehensive care beds to exceed 95 percent.

[31] Note: This computation does not include the number of assisted living units.

It should be noted that SB 146 sunsets on June 30, 2002. The Commission intends to collect data and carefully monitor the impact of this legislation, and the resulting regulations on both the CCRC and nursing home industries.

Statewide, there are currently 30 CCRCs operating in Maryland. Twenty-six (26) of the 30 CCRCs operate their own nursing home facilities as a component of their services available on the campus of the community. As of March 8, 2000, those CCRCs operated a total of 7,618 independent living units, 1,591 assisted living units, and 2,350 nursing home beds.

Of the CCRCs with nursing home facilities, 12 have received a CON exclusion for nursing home beds. The remaining 14 CCRCs have CON approved or grandfathered nursing home beds. As shown in Table 2, the 12 CCRCs with CON exclusions operate a total of 938 nursing home beds. More than one-half of those CON exempt nursing home beds are located in two CCRCs (Charlestown and Oak Crest Village) operated by Erickson Retirement Communities. In addition to facilities currently in operation, data maintained by the Department of Aging indicate that four new CCRCs are currently under development with a total of 539 additional nursing home beds. The development of CCRC nursing home beds, particularly with the recent expansion of direct admission, will have an intensified impact on the utilization of nursing home beds.

Table 2
Maryland Continuing Care Retirement Communities with CON Excluded Nursing Home Beds: March 8, 2000

CCRC	Jurisdiction	Year Opened	Independent Living Units	Assisted Living Beds	Nursing Home Beds
Ginger Cove	Anne Arundel County	1989	243	6	55
Blakehurst	Baltimore County	1993	278	14	54
Charlestown	Baltimore County	1983	1,614	164	270
Glen Meadows	Baltimore County	1990	213	29	31
North Oaks	Baltimore County	1990	183	13	37
Oak Crest Village	Baltimore County	1995	1,528	143	240
Asbury-Solomons	Calvert County	1996	208	30	42
Vantage House	Howard County	1990	220	26	44
Heron Point	Kent County	1991	192	16	36
Buckingham's Choice	Frederick County	2000	207	45	41
Bedford Court*	Montgomery County	1992	215	76	60
Maplewood Park Place*	Montgomery County	1995	207	21	28
TOTAL			**5,308**	**583**	**938**

*Note: In addition to 43 CON-excluded beds, the Commission approved a modified CON allowing Bedford Court to temporarily lease up to 45 CCF beds from Holy Cross Skilled Nursing Facility in November 10, 1992, and granted Bedford Court a CON for 16 comprehensive care ("CCF") beds in 1995; Maplewood Park Place has leased nursing home beds from Bedford Court in addition to having CON-excluded beds.

Another variation on the CCRC model is Continuing Care at Home. This program, which exists in some other states, provides some of the benefits of CCRCs while allowing individuals to stay in their own home. Basic services to be provided include:

- Care coordination;
- Home inspection by an occupational therapist;
- Assistance with activities of daily living at home;
- Skilled nursing services at home;
- Services in assisted living;
- Services in comprehensive care facility;
- Assistance with home maintenance.

An individual would pay an entrance fee for services, with regular, periodic charges, co-payment, or a combination of funding arrangements. Regulations for Continuing Care at Home went into effect in Maryland May 15, 2000. The Department of Aging, which will regulate Continuing Care at Home, does not expect a large number of providers. As of this writing, MDoA estimates that it will receive three applications from prospective providers to initiate this service during the first year.

7. Program for All-Inclusive Care for the Elderly (PACE)

PACE, the Program for All-Inclusive Care for the Elderly, is a capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. PACE features a comprehensive medical and social delivery system using a multidisciplinary team approach in an adult day health center, supplemented by in-home and referral services in accordance with the participants' needs. It was originally based on a program in 1971 called On Lok Senior Health Services in San Francisco. This model provided a range of both acute and long-term care services to an enrolled community. This type of care expanded in 1986 when the Robert Wood Johnson Foundation provided funding for PACE demonstration sites to test if the model could be applied on a broader scale to many types of populations.[32]

The Balanced Budget Act of 1997 established PACE as a permanent entity within the Medicare program and has enabled States to provide PACE services to Medicaid beneficiaries as a state option. PACE beneficiaries need to be frail enough to satisfy their state's requirements for nursing home level of care. The BBA limits annual growth of the PACE program. The number of PACE agreements in the first year is 60 nationally; the limit increases by 20 each year thereafter.[33]

In January 1996, Hopkins Elder Plus initiated a pre-PACE site, which received partial Medicaid capitation for dual eligibles aged 65 and over who were certified for nursing facility level of care. A dual waiver proposal for full capitation by Medicare and

[32] PACE information from HCFA WEBSITE: http://www.hcfa.gov/
[33] Ibid.

Medicaid was jointly submitted to HCFA in June 1998 by The Maryland Department of Health and Mental Hygiene and Johns Hopkins Bayview Medical Center. In January 1999, HCFA approved the waiver proposal, which was implemented in March 1999.[34]

8. Social Health Maintenance Organizations (S/HMOs)

Social Health Maintenance Organizations (S/HMOs) are also based on early models and HCFA demonstration projects. An S/HMO is an organization that provides the full range of Medicare benefits offered by standard HMOs plus additional services which include: care coordination, prescription drug benefits, chronic care benefits covering short term nursing home care, a full range of home and community based services, such as homemaker, personal care services, adult day care, respite care, and medical transportation. Other services that may be offered include: eyeglasses, hearing aids, and prescription benefits. There were four original S/HMOs : Portland, Oregon; Long Beach, California; Brooklyn, New York; and La Vegas, Nevada. Each site has different requirements for premiums; persons do have to pay co-pays for certain services.[35]

In March 1998, HCFA approved Maryland's proposal for a planning grant to build on a Medicare HMO, develop a Second Generation S/HMO (S/HMO II) for Medicare-only and dually eligible (Medicare and Medicaid) older adults, and add long-term care and other services. A framework conference is being planned for the fall of 2000. HCFA approved a no-cost extension of the planning project through June 2001.[36]

A recent study found that S/HMO membership does not offer savings as expected. When comparing the expenditures of enrollees in the Minneapolis S/HMO with those in a TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) HMO, results showed that outpatient services common to both the S/HMO and the TEFRA HMO were about 16 percent higher for S/HMO enrollees, and expenditures for all services were about 20 to 22 percent higher for S/HMO enrollees. The report does not indicate how costs compare to traditional care. The researchers speculate that health care providers might have discovered health problems that would otherwise have gone undetected, recommended medical attention for chronic problems, and helped to link patients with other medical providers, thus causing higher expenditures.

E. Reimbursement

1. Maryland Medical Assistance Program (Medicaid)

Although national attention often focuses on Medicare, the principal payer for nursing homes, both nationally and in Maryland, is the Medical Assistance Program, ("Medicaid"). In fiscal year 1998, Medicaid paid for 62.8 percent of total patient days in Maryland nursing homes. Although Medicaid is the principal payer for nursing home

[34] Information from DHMH WEBSITE: http://www.dhmh.state.md.us/hsaea/
[35] S/HMO information from Medicare Website: http://www.medicare.gov/
[36] Information from DHMH Website, op. cit.

care, it should be noted that Medicaid is the payer of last resort, and pays only when the resident cannot pay. Also, residents must spend down and contribute nearly all pensions and other ongoing income to the cost of their care; they can keep $40 per month as a personal needs allowance.

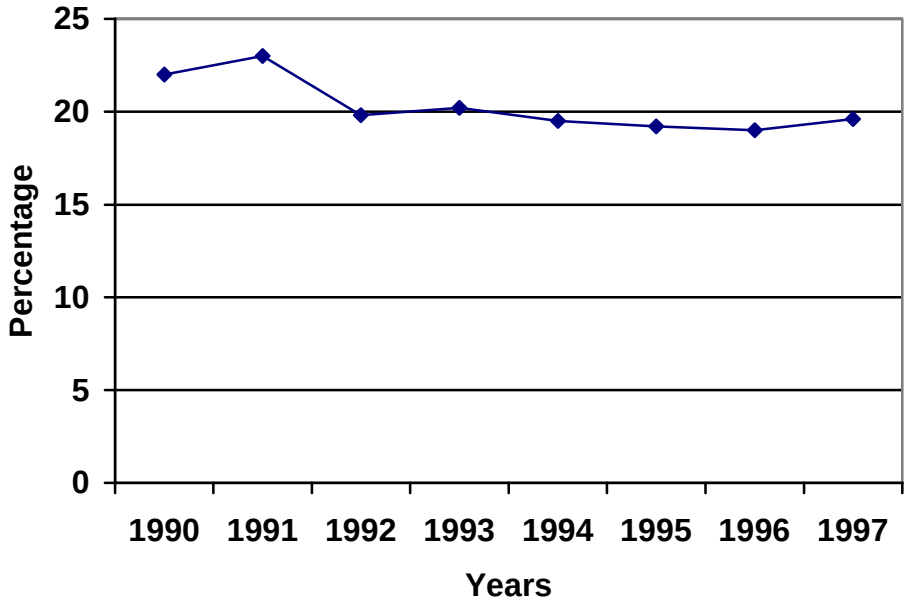
Since Medicaid is a joint federal-state program, the method of reimbursement varies from state to state. In Maryland, payment for nursing home services is based on the level of care required by each resident. It is thus a case-mix adjusted form of reimbursement. Such a methodology is designed to provide a greater incentive for nursing homes in Maryland to serve sicker residents and, on average, Maryland nursing home residents are more dependent in their activities of daily living ("ADLs") than the national average. The American Health Care Association reports that residents of Maryland nursing homes had an average of 3.94 ADL dependencies as compared to 3.67 for the U.S.[37]

The current Medicaid reimbursement system for nursing homes in Maryland has been in effect since 1983. At that time, the objectives were to develop a system that was cost-related and administratively efficient, provided increased access for Medicaid residents, and encouraged quality care. Additional goals were to recognize fair market value of assets used, to recognize factors causing cost differences, and to include incentives for cost containment. There have been adjustments to the system since it was originally designed, but the basic structure has remained unchanged.

The overall system design consists of four cost centers: administrative and routine, nursing service, other patient care, and capital. There are cost ceilings, with reimbursement of costs up to the ceilings and efficiency payments to facilities with costs below the ceilings. The ceiling and efficiency payments are adjusted as needed over time. Reimbursement is based on geographic regions, and includes a small facility class for administrative and routine costs. As Figure 3 indicates, this method of reimbursement has allowed the State to keep the percentage spent by Medicaid on nursing home care at a fairly stable level, even as the population has aged. Although aggregate spending on nursing homes by Medicaid has increased from $272,790,198 in FY 1990 to $559,140,121 in FY 1999, such spending as a percentage of total Medicaid spending has stayed fairly constant over time and actually decreased slightly.

[37] American Health Care Association Nursing Facility Sourcebook, 1998

Figure 3
Spending on Nursing Homes as a Percentage of Total Medicaid Spending



Source: Medicaid Year in Review, 1990-1997

Following recent investigations by the federal General Accounting Office into quality of care in nursing facilities nationwide, more attention has been drawn to improving quality of care issues in Maryland nursing homes by seeking to stabilize the nursing home work force.

As noted above, the current Medicaid rate setting system for nursing facility services in Maryland was implemented on January 1, 1983. The reimbursement approach was intended to provide sufficient payment to enable nursing homes to provide quality care, include incentives for cost efficiency, and create a healthy business climate for nursing home operators. Numerous modifications and updates have been adopted since that time, but the basic methodology is essentially unchanged.

The Medicaid Program has also imposed adjustments to various parameters for cost containment purposed. Since 1992, a prescribed "cycle-down" method has been used to achieve specific amounts of payment reductions in order to meet budget constraints. Reductions have totaled as much as $35 million a year. Although funds have been made available to restore much of these cuts during recent years, reductions of $9.5 million remained in effect as late as Fiscal Year 1999, the latest data available.

In addition, the Medicaid Program's work measurement formula for nursing services in nursing homes, which is intended to ensure that payment for services accurately reflects the time and staff mix required to provide the services, has not been updated since Fiscal Year 1993. Medicaid Program regulations require that the formula be re-calibrated at least every five years, but due to lack of funding to adopt the results of the most recent work measurement study, amendments have been approved for each of the past two years to postpone this requirement. The Department of Health and Mental Hygiene (the "Department") had projected in its Nursing Home Reimbursement Study dated December 1, 1998, the latest available, that implementation of the study results would increase nursing service payments by $23 million in Fiscal Year 2000.

The cumulative impact of the cost containment reductions from January 1991 through Fiscal Year 1999 was $188.5 million, and delay in implementation of the work measurement study results during the past two years has had an additional impact of $43 million. However, even with these cuts in effect, the Department noted that per diem reimbursement rates have increased by an average of 5.3 percent annually during this time. The Department also noted that the number of licensed nursing home beds had increased by 12.5 percent during this same period.[38]

In responding to the cost containment reductions made by the Department, the Health Facilities Association of Maryland ("HFAM"), estimated that the total lost revenue resulting from the State's failure to fund the work measurement study for five years was about $100 million, and the total impact of the reductions through restoration in FY 2000 was close to $300 million. In a letter to the Commission, HFAM noted that the 1994 work measurement study, which was conducted by the Department to determine the time and staff mix for nursing services, showed that nursing time had increased due to the more medically complex resident mix entering nursing homes. In the absence of increased Medicaid reimbursement, nursing homes were forced to postpone needed capital improvements. Additionally, lenders informed nursing homes that they were less willing to loan money due to the inadequate Medicaid reimbursement.

According to HFAM, the payment reductions during most of the 1990s left Maryland nursing homes, particularly those with high percentages of Medicaid residents, ill prepared to weather the impact of managed care, the staffing crisis, loss of private pay patients, decreasing occupancies resulting from competition from assisted living facilities, and the cuts in Medicare reimbursement under the Balanced Budget Act of 1997. [39]

In response to these concerns raised by the State's nursing home industry, the 2000 Maryland General Assembly adopted Senate Bill 794, which called for the re-convening of the Nursing Home Reimbursement Study Group. The bill requires that the state budget include $10 million in General Funds for Fiscal Year 2002 (beginning July 1, 2001), and an additional $10 million in Fiscal Year 2003, to increase payments in the

[38] Nursing Home Reimbursement Study, December 1, 1998, pages 1-2

[39] August 4, 2000 Letter to the Commission from Ann L. Rasenberger, Vice President, Regulatory Affairs, Health Facilities Association of Maryland

Nursing Service Cost Center of the Medicaid nursing home reimbursement formula. The additional funds are to be used to enable nursing homes to address the recommendations of the Task Force on Quality of Care in Nursing Homes. The goals of the Study Group are to:

- Review the existing reimbursement formula to ensure it reflects the current and planned requirements of the nursing home program under Medicaid and the care needs of the nursing home residents;
- Review the proposed funding appropriation for Fiscal Year 2002 and Fiscal Year 2003, and make recommendations for changes to the reimbursement formula to ensure that the intent of the law is achieved; and
- Report its findings to the General Assembly by December 1, 2000.

The Study Group operated with participation from representatives from the nursing home industry, the Service Employees International Union, and State agencies. The Study Group's principles and recommendations, none of which require new legislation or additional funding, are as follows:

Study Group Principles:

- Providers should retain flexibility to use funds for any combination of increased staffing or higher wages.
- Any changes to the reimbursement methodology should maximize the potential for providers to use the new funds in a fashion consistent with the legislation.
- All new funding should be acuity-based.

The recommended changes to the reimbursement formula are maximally consistent with the principals above.

Study Group Recommendations:

- Employ "dual rate-setting" to ensure that new funds are not used as profit.
- Revise the methodology for the calculation of FY 2003 rates.
- Delay work measurement survey until Summer, 2003.
- Alter the cost reporting schedule to avoid an "average cost penalty."
- Establish a one time, two year cost settlement period.[40]

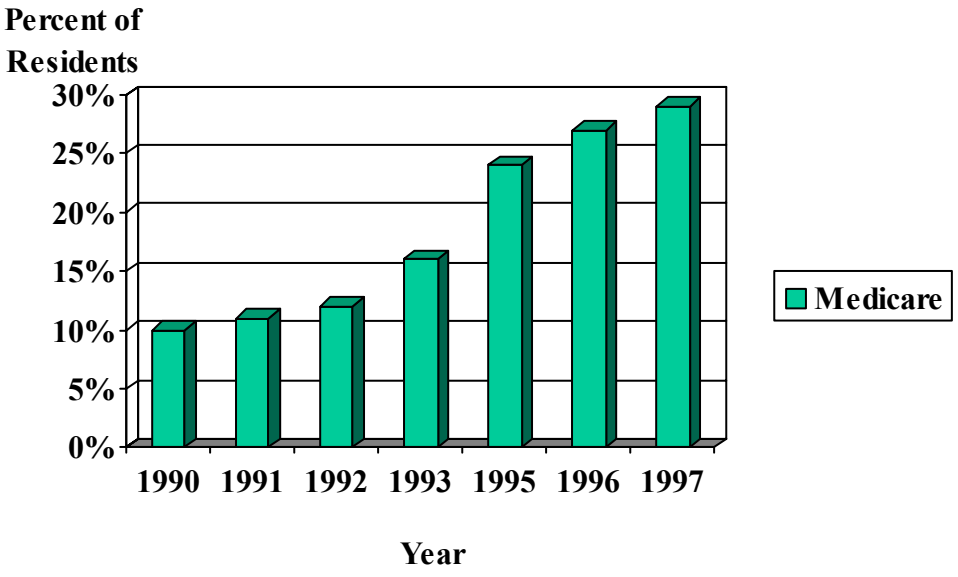
2. Medicare Program

Although a small proportion of nursing home care is reimbursed by Medicare, it is a major payer for short term and subacute care. Until the passage of the Balanced Budget Act, nursing homes enjoyed a system of reimbursement from Medicare which essentially reimbursed whatever they billed, usually a fee based on their costs of care ("reasonable costs"), subject to ceilings adjusted for urban or rural locations. Nursing homes were

[40] Medicaid Nursing Home Reimbursement Study Group, Draft Report, September 29, 2000, p.2.

paid an interim rate, subject to final cost settlement. Although Medicare represents a fairly small proportion of care provided overall in nursing homes (9.3 percent nationally in 1998, as reported by the American Health Care Association), with an increasingly sick patient population, more facilities started to offer skilled nursing care. According to the Health Care Financing Administration ("HCFA"), the percentage of total nursing facility expenditure attributable to Medicare more than tripled from $2.8 billion in 1992 to $10.2 billion in 1997.[41] Since Medicare focuses on paying for post acute care (following a hospitalization) with a limit of up to 100 days, facilities have tried to maximize their Medicare reimbursement by focusing on the provision of skilled care and by developing Medicare distinct part units. Several hospitals and nursing homes also started providing subacute (short-term, post-acute) care as a way of maximizing reimbursements from Medicare. As will be discussed in the next section, this reliance on this source of funding became a major problem for these facilities when Medicare changed its reimbursement methodology with the enactment of the Balanced Budget Act. In Maryland, as shown in Figure 4, payer source on admission attributable to Medicare grew from 10 percent of residents in 1990 to 29 percent in 1997.

Figure 4
Trends in Medicare Payer Source on Admission to Maryland Nursing Homes: 1990-1997



Source: Maryland Long Term Care Surveys, 1990-1997

[41] Childs, Nathan "How Will Long Term Care Remember the Clinton Years?" Provider, November, 1999.

Nationally, Medicare spending in skilled nursing facilities (SNFs) grew from $578 million in 1986 to $13.6 billion in 1998.[42] At the same time, Medicare costs for home health were increasing at an even faster rate. From 1987 to 1994, combined Medicare and Medicaid outlays for long-term care rose by 153 percent for nursing homes and 543 percent for home health care.[43] As a result, the federal government felt that it needed to take drastic action to stop this spiral of increasing costs.

3. Balanced Budget Act of 1997

A significant change to the operation of nursing homes occurred with the enactment of the Balanced Budget Act ("BBA") of 1997. As part of the overall effort to balance the federal budget, Congress passed and the President signed the BBA, which was intended to reduce Medicare payments in 1999 from $248 billion to $232 billion. However, the Congressional Budget office estimated that actual payments for 1999 were only $210 billion.[44] HCFA began phasing in Medicare prospective payment for skilled nursing facilities over four years, beginning July 1, 1998; however, final rules governing the Medicare skilled nursing PPS were not available until July 30, 1999. During the first year, 75 percent of a facility's Medicare payment would be based on its maximum allowable 1995 costs, adjusted for inflation, with 25 percent based on the national PPS rate. Thereafter, the ratio changed to 50:50 for the second year, 25:75 in the third, and 100 percent PPS rate by the fourth year.[45]

Under the BBA, instead of a reimbursement rate based on "reasonable" costs, SNFs receive a set payment for each day of care provided to a Medicare beneficiary. The per diem rate was initially based on the average daily rate of providing all Medicare-covered skilled nursing services in 1995. Since not all patients require the same intensity of care, a case mix adjustment factor was incorporated, permitting some flexibility in the payment calculation. PPS is based on a case mix system of Resource Utilization Groups ("RUG"), which combines routine, ancillary, and capital costs into an all-inclusive case mix-adjusted rate. RUGs are based on data from the resident assessment instrument called the Minimum Data Set (MDS) 2.0. The rate also includes wage adjustments based on geographic variations, using the hospital wage index. Hospital swing beds and low-volume skilled nursing facilities (with fewer than 1500 patient days per year) are not subject to these Medicare PPS rates until 2000.[46]

---

[42] Salganik, M. William. "Golden Years Fade for Nursing Home Chains" The Baltimore Sun, 03/05/00.
[43] Bodenheimer, Thomas, M.D. "Long-Term Care for Frail Elderly People—the On Lok Model." The New England Journal of Medicine, Vol. 341, No. 17, pp. 1324-1327.
[44] Childs, *Id*., November 1999.
[45] HCIA, Inc., and Arthur Andersen LLP, *The Guide to the Nursing Home Industry*, 2000, p. viii.
[46] Health Financial Management Association, "HFMA Knowledge Network Highlights: Skilled Nursing Facilities Prospective Payment System and Consolidated Billing" The requirement was later modified under the BBA Refinement bill, described in the illustrations that follow.

Highlights of the Balanced Budget Act of 1997 Relating to Skilled Nursing Facilities

- **Introduction of a prospective payment system (PPS)**: This payment system, phased in over four years beginning July 1, 1998, gave providers a fixed payment per day to cover all care provided to a resident, as opposed to the former cost-based system. There was an equalization of rates between freestanding and hospital-based SNFs with rates all inclusive of routine, capital, and ancillary costs.

- **Payment based on resource utilization groups (RUGs)**: RUGs have been tested and developed in several phases. These are called RUGs III, representing the third iteration of RUGs. The PPS system is based on 44 RUGs groupings.

- **Therapy Services Caps**: Beginning in 1999, the BBA caps Part B rehabilitation services. There is a cap of $1,500 per year on occupational therapy and a combined cap of $1,500 per year on speech therapy and physical therapy. *

- **Transfer and discharge**: By treating the movement of a patient from a PPS hospital to a SNF or home health agency as a transfer rather than a discharge, the BBA intended to save an estimated $1.3 billion. This reduces the DRG by paying a blended DRG/per diem rate if the patient is moved early from a group of the 10 most frequently used DRGs.

- **Consolidated billing**: SNFs will bill for all covered services provided to residents under Part B with payment being made to the SNF (except physician and physician-related services). *

- **Repeal of the Boren Amendment**: This amendment, enacted in 1980, required that states set Medicaid rates for nursing facilities that are reasonable and adequate to meet mandated federal standards for quality care. This provision of the BBA repealing the Boren Amendment was effective October 1, 1997

- **No Block Grants**: All Medicaid services, including nursing facility services, remain as an entitlement for the poor and disabled. There are no block grants or per capita grants.

- **Asset transfers**: Those who provide legal counsel or assistance in helping a person to knowingly dispose of assets to become eligible for Medicaid can be prosecuted.[47]

After the enactment of the BBA, many nursing homes, subacute care providers, and others complained to HCFA that the cuts were too drastic. Several long term care companies declared bankruptcy. The American Health Care Association, the American Association of Homes and Services to the Aging, and others lobbied against provisions of the BBA with a major advertising and letter writing campaign. The final result was an adjustment to the BBA called the Medicare, Medicaid and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999. This is often referred to as the "BBA Refinement Act".

[47] American Health Care Association (AHCA) Briefing Room, "1997 Federal Budget Act Will Change LTC", August 27, 1997. WEBSITE: http://www.ahca.org/

* This item was modified under The Balanced Budget Refinement Act of 1999.

The Medicare, Medicaid and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 Highlights

- A 6 month add-on to the RUGs III categories: There would be a 20% add-on for six months (beginning April 12, 2000) to more accurately account for non-therapy ancillary costs for 12 RUGs categories**.**
- An increase in the federal rate for all categories of patients by 4% in FY 2001 and FY 2002.
- The option for facilities to go directly to the full federal reimbursement rate, effective with a cost reporting period on or after January 1, 2000.
- Exclusions from the prospective payment system for certain prosthetics, certain chemotherapy, and for ambulance services for dialysis patients, starting April 1, 2000.
- Provisions for Part B add-ons for facilities participating in certain demonstration projects and for those who serve a high proportion of AIDS patients in 2000-2001.
- A 2-year moratorium on implementing the Part B therapy caps and revises the BBA mandated study to develop an alternative system for therapy services payments.[48]

Although these refinements attempt to modify the severity of the initial BBA, the concept of prospective payment and reduction in Medicare payments is still in place. The notion of retrospective payment to cover all or most expenses has been eliminated. This has resulted in, and will continue to require, a major shift in the mindset of long-term care providers.

4. Bankruptcy Among Nursing Home Chains

Because of the major changes in nursing home reimbursement described above, many long-term care companies have merged, or declared bankruptcy, filing under Chapter 11 which gives a company the opportunity to negotiate better interest rates on its debt and streamline its operations by, among other things, shedding unprofitable businesses. Filing for bankruptcy protection provides a company with an automatic stay, preventing the company's creditors from taking any action to collect debt or foreclose on collateral.[49] According to the American Health Care Association, (AHCA), 1,675 skilled nursing facilities out of 17,000 (or about 10 percent) nationally have declared bankruptcy. During the past six months, there were perhaps more bankruptcies among major long-term care providers than at any other time. The most notable of these are listed in Table 3.

[48] Mid-Atlantic Nonprofit Health and Housing Association (MANPHA) Newsletter, December, 1999, p. 2.
[49] Vickery, Kathleen. "Rebuilding through Bankruptcy". Provider, June, 2000.

Table 3
Chapter 11 Bankruptcies Among Nursing Home Chains: 1999-2000

Nursing Home Company	Year of Bankruptcy
Vencor, Inc.	1999
Sun Healthcare Group, Inc.	1999
Mariner Post Acute Network, Inc.	1999
Lenox Health Care, Inc.	1999
Frontier Group, Inc.	1999
Newcare Health	2000
Integrated Health Services	2000
HMU	2000
Genesis[50]	2000

Source: Somerville, Sean and Kristine Henry. "Health Care Companies say Federal Cuts Hurt Industry". The Baltimore Sun, February 3, 2000, p. D-1 and Provider, June, 2000.

Of those listed in Table 3, Vencor, Sun, and Mariner are large national chains. Lenox, Frontier, Newcare, and HMU are smaller, more localized firms. It should be noted that although Integrated Health Care had its headquarters in Maryland, it has no Maryland facilities. Integrated Health Services, which made numerous facility acquisitions in anticipation of less severe cuts, grew to 84,000 employees with $3.0 billion in annual revenue. The company just built a new headquarters in Maryland's Hunt Valley area of Baltimore County, financed in part by the State ($2.5 million) and Baltimore County ($800,000). It had $1.0 billion in equity and $3.0 billion in debt.

Companies that have merged or declared bankruptcy have cited the changes in Medicare reimbursement as the source of their financial woes. Although it is true that the drastic changes in the form of a prospective payment system did cause serious downturns with these markets, this was an announced, anticipated change, which many other companies managed to weather. The ones that were the most severely impacted were heavily invested in Medicare post-acute products, had over expanded the number of their sites, and were also heavily in debt. Most of the losses were due to "one-time transactions, including cost restructuring and the writing down of assets."[51]

The bankruptcy woes seemed to hit the larger chains harder than some of the smaller nursing homes providing more "traditional" types of nursing care. "Some nursing homes, particularly those that belong to large chains, had increased their profitability by expanding into ancillary services, thus increasing their volume of Medicare subacute patients. Adding these services often required borrowing capital, placing the homes in a debt situation that is hard to reverse when revenues decline. Also, the PPS system placed limits on reimbursement for ancillary services, for which these

[51] Adams, "Medicare: New Rules Make Nursing Home Admission Harder". Wall Street Journal, December 23, 1999.

entities had signed contracts, so these homes are now being hit even harder than most. Indeed, the stock prices of some of the large chains demonstrate their strain—in 1998, the stock prices of the eight largest publicly traded subacute and long-term care companies fell by an average of 56.7 percent. The second worst year, historically was 1988, when the drop was only 10 to 15 percent."[52] So, it appears reasonable to assume that a combination of factors and actions caused the financial situation for these companies.

Regardless of the root cause, the bankruptcies of nursing home chains may well have an impact not only on the nursing home system, but also on the broader health care system. If nursing homes, due to fears of BBA impact, refuse to take complex medical and rehabilitation patients, such patients will be backed up in hospitals. If home health agencies are undergoing a budget crisis at the same time, this will also put pressure on hospitals. Due to pressure from managed care organizations, hospitals are also more rapidly discharging patients at higher acuity levels; this is putting pressure on the entire health care system, and especially on the patients whom no one seems to consider.

Although much has been written about the draconian effects of the BBA, Maryland appears to have been spared some of the negative consequences. This is due, in part, to the fact that it has long had a case-mix adjusted Medicaid reimbursement system. Such a system provides greater incentives for facilities to accept sicker Medicaid patients than a flat rate reimbursement system. Thus, in general, facilities are less dependent on Medicare here than elsewhere.

To better gauge the impact of the BBA in Maryland, HCFA is currently participating with four other peer review organizations on the Skilled Nursing Facility Prospective Payment System Quality Medical Review Pilot Project. The Maryland team is comprised of The Delmarva Foundation for Medical Care ("Delmarva"), the Maryland Office of Health Care Quality, Maryland Medicare/Blue Cross and Blue Shield of Maryland, and the Medical Care Finance and Compliance Administration of the Department of Health and Mental Hygiene. Delmarva developed a questionnaire that was distributed to consumers, providers, trade organizations and other interested organizations and returned with a 32 percent response rate. Results included the following findings:

- 54 percent responded that since the implementation of PPS, staffing in nursing homes has declined; there is a 45 percent increase in use of agency nurses.

- Skilled Nursing Facilities ("SNFs") did not report any increase in patient falls, episodes of patient dehydration, or acquisition of pressure ulcers.

- SNFs noted a 67 percent increase in patient acuity and 68 percent have made admission requirements more stringent.

- 62 percent of the hospitals reported an increase in readmissions from SNFs.

[52] HCIA Guide, 1999.

- 76 percent of hospitals report an increase in length of stay for patients awaiting SNF placement.[53]

It should be noted that these are preliminary findings and that replies represent only a 32 percent response rate. Further data and results from this study are expected later this year.

5. Nursing Home Mergers/Acquisitions in Maryland

Mergers of long term care facilities in Maryland have occurred with increasing frequency in recent years. This may be due in part to the BBA, since mergers can consolidate billing and other administrative expenses, but it may also just be a sign of the times where it is much more difficult for smaller nursing homes to survive. The chains, both national and local, that operate more than one facility in Maryland, are listed in Table 4. As this table indicates, 10,839 beds out of the statewide total 30,300 (or 36 percent) are operated by owners of seven multi-facility chains in Maryland.

Table 4
Companies Operating Multiple Nursing Home Facilities in Maryland: 2000

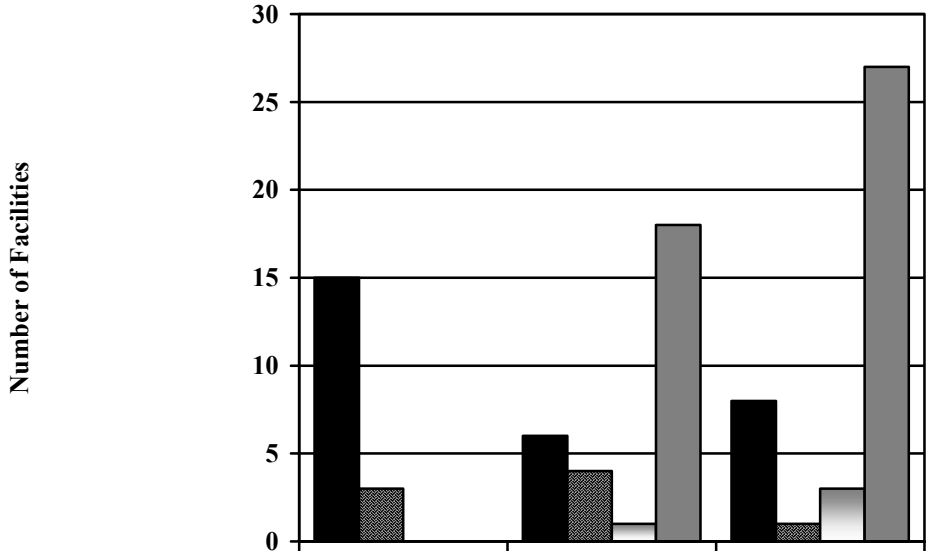
Name of Company	Number of Facilities	Number of Beds
Genesis Eldercare	26	3,952
Mariner-Paragon	13	2,249
Manor Care	10	1,481
Futurecare	8*	1,192
Millenium	5	516
Meridian Elder Trust	5	771
Lorien	3**	678
TOTAL	70	10,839

Source: MHCC CON Files
*Futurecare has 8 nursing homes and 3 subacute facilities
**Lorien has 3 existing facilities and 4 under development

In Maryland, as in the rest of the country, there has been a great deal of merger activity during the past three years. Some of it has been related to changes in ownership of the facility, changes in who owns the license, or both. More recently, mergers and acquisitions have been the result of corporate restructuring. These activities, which have increased from a total of 18 facilities in 1997 to 39 in 1999, are illustrated in Figure 5.

[53] Rodgers, Roxanne, Delmarva Foundation. "HCFA Skilled Nursing Facility Prospective Payment System Quality Medical Review Pilot Project", June 30, 2000.

Figure 5
Maryland Facilities Involved in Nursing Home Acquisitions: May 1997-January 2000



	1997	1998	1999
Licensee & Owner	15	6	8
Licensee Only	3	4	1
Owner Only	0	1	3
Corporate Restructuring	0	18	27

Source: Maryland Health Care Commission (Data reported based on CON project files)

F. Quality of Care

1. Federal Quality of Care Initiatives

Nursing homes have suffered in the past few years from the simultaneous cuts in reimbursement coinciding with increased scrutiny in areas of quality of care. For context and perspective on the impact of these changes, one needs to have a brief history of the quality of care initiatives that have been launched in this area.

Federal Quality of Care Initiatives:

1986: The Institute of Medicine conducted a study of nursing home regulations and reported prevalent problems regarding the quality of care and the need for stronger federal regulations.
1987: The General Accounting Office (GAO) reported that over one third of nursing homes are operating below federal minimum standards. This led to the passage of the Omnibus Budget Reconciliation Act (OBRA of 1987). Part of OBRA 1987 was the comprehensive Nursing Home Reform Act (PL 100-203), which included, among other things, the development of the minimum data set (MDS).
1991: HCFA's OSCAR (Online Survey Certification and Reporting System) came online in October 1991. It listed reports for 3 previous surveys.
1995: The Nursing Home Reform Act led to new enforcement provisions outlined in the State Operations Manual (SOM) in July 1, 1995. A new HCFA certification process also began in 1995. The Ombudsman Program, which was created in 1978 under the Older Americans Act, developed the NORS (National Ombudsman Reporting System) in 1995.
1997: In 1997, the Office of the Inspector General (OIG), in a report entitled "Safeguarding Long Term Care Residents", reported great diversity in ways that states investigate patient abuse. A more in-depth audit of Maryland facilities examined eight nursing homes and found that 5% of employees had criminal records.
1998: In March 1998, Charlene Harrington published a study entitled: "The Regulation and Enforcement of Federal Nursing Home standards". She challenged the declining State deficiency averages by raising the notion that the enforcement process may be weakening rather than nursing facilities improving their quality of care. In July 1998, President Clinton announced new nursing home initiatives to provide enhanced protections and to target needed improvements in nursing home care. He called on HCFA to impose penalties on nursing facilities without establishing a grace period, inspect facilities with poor records more frequently, and establish a national databank so consumers could compare facilities against one another. Following his recommendation, HCFA granted states greater latitude to impose fines as high as $10,000 per survey infraction, eliminated grace periods for facilities with repeated violations, and pushed states to begin criminal investigations of complaints about harm to residents within 10 days. Also, in 1998, the GAO report on quality of care in 1,370 California nursing homes revealed that 30% had violations that caused death or life-threatening harm to residents, or had understated the frequency of poor care by falsifying medical records. This led to hearings held during the summer of 1998 by the Senate Special Committee on Aging.
1999: In March 1999, the OIG released a report entitled: "Quality of Care in Nursing Homes: An Overview". Among its findings: 13 out of 25 "quality of care" deficiencies have increased in recent years; ombudsman complaints have been steadily increasing; since 1995 the OIG has excluded 668 nursing home workers from participation in the Medicare/Medicaid program as a result of a conviction related to patient abuse or neglect. Recommendations include: enhance the survey and certification process; strengthen the ombudsman program; improve nursing home staffing levels; improve coordination between state survey agencies and ombudsman; a systematic assessment of OBRA 1987; and create periodic report cards on conditions in nursing homes. Also in March 1999, the GAO released a report entitled: "Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards." They found that more than one fourth of the nursing homes studied had deficiencies that caused actual harm to residents, or placed them at risk of death or serious injury. Furthermore, sanctions initiated by HCFA were never implemented in a majority of cases, and generally there was no mechanism to ensure that the homes maintained compliance with standards. Recommendations include: improve the effectiveness of civil money penalties; strengthen the use of and effect of termination; improve the referral process (referral to HCFA for sanction); develop better management information systems. In the summer of 1999, HCFA added 24 quality indicators to its survey process for Medicare-certified facilities. Facilities receive a percentile rank for each indicator that shows how the facility compares with others in the state. Facilities with an unfavorable rank will face more scrutiny by state surveyors, particularly in the area of concern. Also, HCFA will now place immediate sanctions on any facility that receives two consecutive survey citations for isolated incidents that involve actual harm to at least one resident.[54]

[54] Office of the Inspector General, Quality of Care in Nursing Homes: An Overview, March 1999 (OEI-02-99-00060). Also General Accounting Office, Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards, March, 1999 (GAO/HEHS-99-46).

2. State Quality of Care Initiatives

At the same time as these federal initiatives have occurred, the State of Maryland has also launched its own quality of care investigation. Senate Bill 740 and House Bill 791, passed during the 1999 General Assembly, required the creation of a Task Force on Quality of Care in Nursing Facilities. The bill also called for reform of Medicaid's reserve bed payment policy and establishment of a nursing home report card to be prepared by the Maryland Health Care Commission. This was done as a result of two developments: growing recognition that nursing homes were severely understaffed resulting in a decline of quality of care, and issues raised by the March 1999 federal General Accounting Office ("GAO") report which severely criticized Maryland's regulatory oversight of the nursing home industry. Findings of the GAO Report include findings that Maryland:

- dedicated fewer resources to investigating complaints than other states surveyed;
- recorded substantially fewer complaints than Michigan or Wisconsin, two other states surveyed by the GAO on this particular matter;
- generally classified similar complaints as needing less prompt investigation;
- did not meet the assigned time frames for investigating many complaints; and
- had a large backlog of uninvestigated cases and poor tracking of the status of investigations.

The GAO report found, "as a consequence, serious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months in Maryland. Such delays can prolong situations in which residents may be subject to abuse or neglect resulting in serious care problems like malnutrition and dehydration, preventable accidents, and medication errors."[55]

[55] General Accounting Office. Nursing Homes Complaint Investigation Processes in Maryland. June, 1999. (GAO/T-HEHS-99-146)

The Maryland Nursing Home Task Force met from July to December of 1999. It included public comments from all major stakeholders, and issued the following findings:

- Nursing home residents have more complex and acute medical needs than in previous decades.
- Personal care needs of residents are not being met. There has been a decline in the quality of care in Maryland's nursing homes.
- Nursing Assistants, who provide most of the care in the homes, are in a position with little mobility, limited opportunity, and poor pay. The result is large turnover in these positions and continued staff shortages.
- The Balanced Budget Act of 1997 reduced federal reimbursement to nursing homes.
- The 1998 federal nursing home initiatives (NHIs) have had a major resource impact on Maryland's regulatory system. This impact is compounded by the Office of Health Care Quality's (OHCQ) difficulty in recruiting qualified survey staff.
- In response to the GAO report and new directives from HCFA, OHCQ has made complaint investigation a higher priority.
- State licensure laws for enforcing action against nursing homes with poor quality of care are not effective. These laws do not lead to early intervention and the encouragement of nursing homes to achieve and maintain compliance with standards. At present, enforcement action for nursing homes with poor quality is dependent on federal regulations.
- Maryland nursing homes are not practicing internal health quality assurance and as a result are less proactive in dealing with issues.
- Advocacy efforts on behalf of nursing home residents are underfunded and need to be strengthened. In particular, the long-term care ombudsman program does not have the resources to do its job.
- Family Councils can be a valuable source of advocacy for residents, provided that they operate independently of nursing home administration.

Recommendations from the Maryland Nursing Home Task Force included:

- Continue the Task Force as an oversight committee to monitor progress on the implementation of its recommendations.

- Increase minimum staffing standards for resident care in nursing homes to four hours per resident per day, with unlicensed direct care staffing set at a minimum of three hours per resident per day.

- Improve the quality of the nursing home workforce.

- Strengthen State regulation of nursing homes.

- Improve quality assurance programs in nursing homes.

- Strengthen consumer advocacy, including the long-term care ombudsman program.

Another provision of SB 740 required that the Maryland Health Care Commission, in consultation with the DHMH and the Department of Aging, to "develop and implement a system to comparatively evaluate the quality of care and performance of nursing facilities on an objective basis". The Commission formed a Nursing Home Report Card Steering Committee to develop nursing home report cards. In May 2000, this Steering Committee issued a Request for Proposal ("RFP") for bids on the development of a work plan for a conceptual model report card. An Evaluation Committee, a subcommittee of the Steering Committee with the addition members of Commission Staff, was formed to evaluate the bids. The Evaluation Committee agreed, by consensus, that the overall proposal submitted by ABT Associates, Inc. ("ABT") provided the most advantageous offer to the State of Maryland. The Commission is required to make a progress report on the nursing home evaluation system to the General Assembly by January 1, 2001, and the evaluation system must be implemented on or before July 1, 2001.

During the 2000 session of the General Assembly, quality of care in nursing homes was again a major focus of activity. Following the work of the Maryland Nursing Home Task Force, seven bills addressing quality concerns were considered, and six passed. Briefly described, these bills included the following provisions:[56]

- **HB 784/SB 794**: $40 million added to the Medicaid budget over the next two years to support increased staffing in nursing homes. A provision increasing staffing requirements to 4.0 nursing hours per day was defeated.

- **HB 747/SB 690**: Requires nursing homes to create a quality assurance program, a quality assurance committee, a written quality assurance plan; requires facilities to post staffing ratios.

- **HB 634/SB 689**: Provides authority to the Department of Health and Mental Hygiene to impose sanctions and penalties, including civil money penalties, instead of just relying on federal sanctions and penalties.

- **HB 748/SB 698:** Continues the Nursing Home Task Force as an oversight body.

- **HB 749/SB 688:** Requires DHMH to conduct two full inspections each year unless a facility has been deficiency-free in two consecutive surveys.

[56] Appendix B contains a more detailed synopsis of these legislative measures.

- **HB 865**: Authorizes a budget increase of $1.9 million over the next three years, to expand the State's long term care ombudsman program.

Another effort in the area of quality of care in nursing homes is a joint program of the Mid-Atlantic Non-Profit Health and Housing Association (MANPHA), the Maryland Medical Directors Association (MMDA) and the Health Facilities Association of Maryland (HFAM), to develop clinical practice guidelines for use in nursing homes. The Maryland Office of Health Care Quality will recognize use of these guidelines as an initiative under the Omnibus Budget Reconciliation Act ("OBRA") regulations.

III. GOVERNMENT OVERSIGHT OF NURSING FACILITY SERVICES IN MARYLAND

Government oversight of nursing homes, including facilities, staff, and program operation, is principally the responsibility of six agencies: the Maryland Department of Health and Mental Hygiene's Office of Health Care Quality and the Medical Care Programs ("Medicaid"), the Board of Physician Quality Assurance ("BPQA"), the Board of Nursing, and the Maryland Health Care Commission ("MHCC"), and the Maryland Department of Aging ("MDoA") . Although this report focuses on the oversight responsibilities of the MHCC and the options for potential changes in regulation, for context and perspective, it is important to consider how nursing home services are regulated by other agencies of state government.

The history of nursing homes in the United States has been one of constant change. Starting in the 1960s with the passage of Medicare and Medicaid as a source of reimbursement, nursing homes evolved from old age "rest homes" to major providers who offered an increasingly medical model of care. With the enactment of prospective payment for hospitals in the 1980s, nursing homes found themselves taking care of increasingly more medically complex patients as hospitals discharged patients "sicker and quicker". The development of alternatives to nursing homes in the 1980s and 1990s and the Balanced Budget Act of 1997 further increased the turmoil for nursing homes as they struggled to redefine their mission. For more details on the evolution of government policy initiatives relating to nursing homes and the general long term care system in Maryland, see Appendix A.

A. Department of Health and Mental Hygiene

Demographic, social, and economic changes have prompted the federal government and State of Maryland, through their agents noted below, to address issues related to nursing homes since the implementation of Medicaid, Medicare, and the Older Americans Act in 1965.

1. Office of Health Care Quality

The Office of Health Care Quality ("OHCQ"), an administration within the Department of Health and Mental Hygiene ("DHMH"), is responsible for overseeing the quality of care and compliance with both state and federal regulations in health-related institutions in Maryland, including nursing homes. The Long Term Care Unit of OHCQ is responsible for licensing all nursing homes and certifying them for participation in Medicare and/or Medicaid. COMAR 10.07.02.05A requires nursing homes to be open at all times for "inspection by the Secretary of Health and Mental Hygiene, or by any agency designated by the Secretary." OHCQ is also responsible for licensing Assisted Living facilities and Adult Day Care Centers. In addition, OHCQ investigates quality of

care complaints from the general public and those referred by the State's insurance commissioner.

In a cooperative partnership with the Health Care Financing Administration ("HCFA"), the Medical Care Finance and Compliance Administration of the Department of Health and Mental Hygiene, Maryland Medicare/Blue Cross and Blue Shield of Maryland (the Medicare fiscal intermediary), and the Delmarva Foundation for Medial Care, the OLCQ has joined in the HCFA Skilled Nursing Facility Prospective Payment System Quality Medical Review Pilot Project ("SNF PPS QMR Pilot Project"). This project, which described in Part II, is testing a data driven and cooperative quality medical review approach to assess, monitor, and improve the quality of Medicare skilled nursing facility services under the Prospective Payment System.

2. Maryland Medical Care Program (Maryland Medicaid)

Under the Maryland Medical Assistance Program ("Medicaid"), nursing home services are covered for medically and financially eligible Medicaid recipients. A recipient must be certified by the Program's Utilization Control Agent, the Delmarva Foundation for Medical Care, as requiring health related services above the level of room and board which can be provided only through institutional services. In fiscal year 1998, the most recent date for which data are available, services were provided in 205 nursing facilities statewide. This represents approximately 77.07 percent of the 266 licensed nursing homes in Maryland in 1998.[57]

As noted above, nursing facility reimbursement rates are set by the Medicaid Program using a system originally developed in fiscal year 1983, but refined further since that time. Under this reimbursement methodology, separate rates are set for four cost centers and are based on the size, geographic location, and expenditures of each nursing facility. These cost centers are: administrative/routine services, nursing services, other patient care, and capital costs. Payment for nursing services is based on the level of care required by each patient.

According to an analysis provided by DHMH, the Medicaid Program's average per diem payment for nursing home services was $85.72 in fiscal year 1998, the most recent date for which data are available. This average per diem represents an increase of 8.5 percent from the fiscal year 1997 average of $78.97. Payment from patients' own resources and collections in fiscal year 1998 accounted for an average of $20.90, 5.0 percent higher than the average of $19.91 in fiscal year 1997.

Additional oversight of nursing home admissions is in the form of the Statewide Evaluation and Planning Services ("STEPS"), a pre-admission screening program for which Medical Assistance reimburses providers for conducting long term care evaluations. These comprehensive evaluations are conducted by licensed social workers and registered nurses working in Adult Evaluation and Review Services ("AERS"),

[57] This figure represents comprehensive beds in both nursing homes and continuing care retirement centers.

formerly the Geriatric Evaluation Services ("GES"), located in local health departments and include medical/nursing, psychological and functional assessments. Following each evaluation, this multidisciplinary team develops an individualized plan of care which recommends services that could appropriately substitute for nursing facility care and enable the individual to remain in the least restrictive environment.

The Medical Assistance Program pays for the STEPS evaluation and multidisciplinary assessment for an individual who is determined to be financially and medically eligible. Financial eligibility includes a Medical Assistance recipient or a person who would be able to establish financial eligibility for Medical Assistance within six months, if admitted to a nursing facility. Medical eligibility is for a person who is certified by the Department or its designee as requiring nursing facility level of care, or a person who is at risk of needing nursing home services. In fiscal year 1997, STEPS providers were reimbursed $275 per evaluation for 11,439 completed evaluations, totaling $3,145,725.

In addition, in January 1989, the State was mandated to implement Pre-admission Screening and Annual Resident Review ("PASARR") under the Omnibus Budget Reconciliation Act of 1987 ("OBRA 87"). The act requires pre-admission screening and annual resident review of individuals with mental illness or mental retardation and related conditions who are applicants to, or residents of, Medicaid certified nursing homes. These individuals are evaluated by the AERS teams located in the local health departments. The teams are composed of nurses, social workers, psychiatrists and psychologists. If an individual's needs cannot be met in the community, the team evaluates whether the individual requires the level of services provided by a nursing home, and if specialized services are needed. A plan of care that recommends appropriate services for each individual is developed in a multidisciplinary setting. Upon review of the recommendations, the State Mental Hygiene Administration makes determinations for individuals with mental illness and the State Developmental Disabilities Administration makes determinations of individuals with mental retardation. Total payments for PASARR during fiscal year 1997, the most recent data available, were $1,006,605 for 2,409 claims.[58]

For further information on the State's efforts to place individuals in the least restrictive environment, see sections of this paper in Part II on the Medicaid Home and Community-Based Services Waiver for Older Adults and the Medicaid Home and Community-Based Services Waiver for Adults with Physical Disabilities.

B. Board of Physician Quality Assurance and Board of Nursing

Health occupation regulatory boards associated with DHMH oversee the licensure of health professionals in Maryland. The Board of Physician Quality Assurance ("BPQA") will accept and investigate complaints it receives regarding physicians. Additionally, the Board of Nursing oversees licensure of nurses and the certification of certified nursing assistants.

[58] Maryland Medical Care Programs, The Year in Review: Fiscal Year 1997 and 1998, p. 10.

C. Maryland Insurance Administration ("MIA")

The Maryland Insurance Administration ("MIA") provides for the licensure of insurers and agents, establishment of financial and capital standards for insurers of all types, requirements for rate making and disclosure, and for fair practices. Consumer complaints regarding coverage decisions and appeals of medical necessity decisions made by HMOs or insurers are handled through the MIA. The Administration's Division of Life and Health is responsible for regulating life, health (including long-term care), HMO, annuity, and dental plan insurance lines.

In an effort to provide customer information in the area of health insurance, the Maryland Insurance Administration publishes a series of publications including, but not limited to the following:

Health Insurance for Small Businesses—Rate Comparison Guide. This guide provides a comparison of premiums for the Comprehensive Standard Health Benefit Plan for all health insurance companies using a model group.

Consumer's Guide to Health Insurance in Maryland This publication provides information about health care coverage, including an explanation of how health insurance works, types of health insurance available, shopping tips, options if consumers cannot afford health coverage, how to file a complaint and frequently asked questions.(To be available on-line Winter 2000)

Additionally, the MIA distributes the following health insurance-related publications produced by federal agencies or the National Association of Insurance Commissioners ("NAIC"):

NAIC Shoppers Guide to Long-Term Care which assists consumers in understanding long-term care and the insurance options that can help pay for long –term care services.

Guide to Health Insurance for People with Medicare which offers assistance in the purchase and use of Medicare supplemental or Medigap insurance. The guide also includes information on other kinds of health insurance (i.e. group insurance, retiree coverage, etc.) and long-term care insurance. This is produced annually by the U.S. Health Care Financing Administration.

D. Maryland Department of Aging ("MDoA")

In addition to its previously discussed role in the review and approval of CCRCs, the Maryland Department of Aging is responsible for taking the lead in the planning, coordination, and delivery of programs and services for older Marylanders to promote their health and well-being. These services are provided at the local level, through Maryland's nineteen Area Agencies on Aging. These Local Area Agencies either

provide services directly to older persons or contract with other public or private agencies to administer programs. To accomplish its mission, the Department receives state general funds and federal funds authorized through the Older Americans Act and other sources.

One of the resources that the MDoA provides is Client and Advocacy Services. Among the activities this service affords to elderly persons are: Services to Frail Older Individuals, Elder Abuse Prevention, Senior Legal Assistance, Public Guardianship, Senior Health Insurance Counseling and Advocacy (Senior HICAP), Senior Care, and Long Term Care Ombudsman. Senior Care is a statewide long-term care service delivery system which coordinates community-based services to individuals 65 and older, according to their needs.

In the Long Term Care Ombudsman Service, local ombudsmen receive, investigate, and seek to resolve complaints from, or on behalf of, residents of long term care facilities (nursing homes). During the course of the closure of a nursing home, the role of the local Long Term Care Ombudsman is to monitor the closure and respond to requests for assistance from nursing home residents or family members. The State Ombudsman is responsible for training local ombudsmen, providing technical assistance, and providing the overall leadership for the program.

E. Office of the Attorney General of Maryland, Division of Health Education and Advocacy

This division within the Office of the Attorney General of Maryland provides a Consumer Hot Line which serves as a conduit to callers directing them to agencies within State government which could best help resolve concerns related to nursing homes, other health care billing, and provider questions. Additionally, this division may help a consumer who is involved in an appeal process related to a nursing home issue. Monitored by mediators with experience in both the insurance and provider industries, some two dozen volunteers answer consumer calls.

In cooperation with the Maryland State Bar Association, the University of Maryland School of Law's Law and Health Care Program, the Maryland Department of Aging, and the Legal Aid Bureau, Inc., this part of the Consumer Protection Division of the Maryland Attorney General's Office also periodically publishes Nursing Homes: What You Need to Know. The latest revised edition was in 1998. The book is a compact compendium which presents what choices and alternatives one has when considering a nursing home, what to expect in nursing home care, consideration of planning one's finances and payment for nursing home care, as well as resources of where to get help with questions related to nursing homes.

F. Maryland Health Care Commission ("MHCC")

Through the health planning statute, the Maryland Health Care Commission ("MHCC") is responsible for the administration of the State Health Plan, which guides decision making under the Certificate of Need program and the formulation of key health

care policies, and the administration of the Certificate of Need program, under which actions by certain health care facilities and services are subject to Commission review and approval.[59] Through the Certificate of Need program, the Commission regulates market entry and exit by the health care facilities and individual medical services covered by CON review requirements, as well as other actions they may propose, such as increases in bed or service capacity, capital expenditures, or expansion into new service areas.

"Certificate of Need" as a regulatory tool has three levels, each initiated by a written notice or letter of intent to the Commission. For confirmation that a Certificate of Need is not required to establish a certain kind of health care facility or service, a person requests a "determination of coverage" by CON requirements. Staff and counsel analyze the proposal according to the Commission's statute and applicable regulations, and, if CON review and approval is not needed to undertake the project, the Executive Director issues a determination to that effect as the Commission's designee.

Proposed new health care facilities and specified actions by existing facilities that do require CON approval come to the Commission either in response to a schedule regularly published in the *Maryland Register*, or, if no schedule has been published for a particular service, as an unscheduled review. Procedural rules dictate how unscheduled reviews must be administratively handled so as to permit a comparative review for the new service, if that is appropriate or practical.

The CON review itself proceeds according to additional rules set forth at COMAR 10.24.01, evaluates an application against all applicable standards and need projections for the service in the State Health Plan, and applies six general review criteria related to the need for and the likely impact of the proposed project on the health care system. Statute requires that staff (or a Commissioner appointed as a reviewer in a comparative or competitive review) bring a recommendation on a proposed project to the full Commission within 90 days of docketing.[60] The first thirty days after docketing are set aside as a public comment period, in which interested members of the public, as well

---

59 The MHCC also establishes a comprehensive standard health benefit plan for small employers, and evaluates proposed mandated benefits for inclusion in the standard health benefit plan. In its annual evaluation of the small group market, the Commission considers the impact of any proposed new benefits on the mandated affordability cap of the small group market's benefit package, which is 12 percent of Maryland's average wage, and the impact of any premium increases on the small employers. With regard to nursing-home level care, Maryland's Comprehensive Standard Health Benefit Plan for Small Businesses currently includes a "skilled nursing facility care" benefit characterized as "100 days as an alternative to otherwise covered care in a hospital or other related institution, i.e. nursing home," which carries "a $20.00 co-payment or applicable coinsurance, whichever is greater."

[60] Docketing is the formal start of a CON review; the time period in which a recommendation is to come to the full Commission is 150 days, if an evidentiary hearing is held. However, 1995 legislation to streamline the CON review process mandated the adoption of regulations that restrict evidentiary hearing to those cases in which the "magnitude of the impact" of a potential new facility or service merit the additional time and transactional cost.

as "interested parties" in the legal sense, may comment on the proposal or, if they meet criteria in regulation, enter the review in opposition to the project.

Since 1985, health planning statute has permitted the Commission to find, "in its sole discretion," that certain actions by existing health care facilities -- if the facilities proposing them are merging, or have merged and are proposing to further consolidate or to reconfigure their bed capacity or services – may be exempted from the Certificate of Need requirement that would otherwise apply. This so-called "exemption" from the CON requirement may be granted through action by the Commission for several kinds of actions proposed "pursuant to a consolidation or merger" of two or more health care facilities, if the proposed action:

- Is "not inconsistent with" the State Health Plan[61];
- "Will result in the delivery of more efficient and effective health care services"; and
- Is "in the public interest."[62]

A merged asset system seeking such a finding by the Commission must provide notice of its intent at least 45 days before it requests action on the proposal. Additional procedural regulations (at COMAR 10.24.01.04C) require the Commission to provide notice to the public, with the opportunity to comment on the proposed action.

Market Entry: Certificate of Need Review of Proposed Nursing Home Projects

Entry into the market for proposed new nursing homes, and for expansion of bed capacity at existing facilities, has been regulated through Certificate of Need since the creation of the former Health Resources Planning Commission in 1982, and had required CON approval under the HRPC's predecessor agency, since the inception of CON in Maryland. COMAR 10.24.08, the State Health Plan chapter governing review and approval of long term care services, permits the Commission to docket for review a CON application to establish or expand a nursing facility only if the bed need projection currently in effect shows unmet need for new beds in the jurisdiction in question.[63]

---

61 "Or the institution-specific plan developed and adopted by the Commission," pursuant to its authority at Health-General Article §19-122, Annotated Code of Maryland.

[62] Health-General §19-123(j)(2)(iv).

[63] COMAR 10.24.08.05C sets forth the docketing rules for nursing home CON applications. Although the Commission's need projection for the year 2000, currently being updated as part of the larger update of the entire Plan chapter, still shows bed need in both Harford County (137 beds) and on the Eastern Shore (aggregated by regulation for the region, at 139 beds), the former HRPC denied multiple applications in those two areas, in the last comparative reviews with evidentiary hearings, under the former procedural rules for CON review. Neither the Plan nor CON regulations obligate the Commission to approve previously-projected need if present occupancies or the proposed projects themselves do not warrant approval. The last new nursing facilities approved to meet projected need for 2000 were projects in Frederick County (11/95) and Carroll County (2/96). See Table XX below.

The analysis of applications for CON approval for new or expanded nursing homes evaluates how the proposed project meets the applicable standards, policies, and need projections in the State Health Plan, and how it addresses the six general review criteria found in the Certificate of Need procedural regulations at COMAR 10.24.01.08G(3).[64] The other element of CON review, the currently-applicable bed need projection, is derived through a set of assumptions about the State's available inventory of nursing home beds and about the use rates and origin of nursing home patients in different age groups, applied to population and demographics. A concise description of the Commission's nursing home bed need methodology is attached to this paper as Appendix E.

The State Health Plan rules and standards that are applied to CON reviews of proposed new facilities or expansions (beyond the statutory "waiver bed" rule that permits increases of 10 beds or 10% of total beds, whichever is less, two years after the last change in licensed capacity) fall into several distinct categories. "Program policies" articulated in the Plan (at COMAR 10.24.08.05) establish rules governing the start and the basic categories of nursing home reviews, and also include rules that apply to other CON-related actions such as the creation and permitted use of waiver beds in nursing homes. The general categories of program policies include:

- **docketing standards**, which determine whether applications for new facilities or expansions will be accepted and may be docketed for review;
- **approval rules**, which set baseline standards for the kinds of proposed projects that may be granted CON approval if otherwise consistent with service-specific standards and projected need; and
- **preference standards**, which give an edge in a comparative review to proposed projects that will achieve goals identified by the Plan as desirable (such as optimally-sized nursing units, increased geographic access, or conversions of former acute care hospitals.)

The Plan standards at COMAR 10.24.08.06, taken together, provide a composite description of what the Commission has established, through its staff research, deliberation, and the public adoption process that produce the goals and policies of the State Health Plan, a nursing home in Maryland should be and do for its residents. These standards require nursing homes to serve mentally-impaired residents, including those with Alzheimer's disease and other dementias, to provide or support the provision of community-based services such as adult day care; and to address the needs of any non-elderly residents.

[64] In brief, these criteria require an application to: (1) address the State Health Plan standards applicable to the proposed project; (2) demonstrate need for the proposed new facility or service; (3) demonstrate that the project represents the most cost-effective alternative for meeting the identified need; (4) demonstrate the viability of the project by documenting both financial and non-financial resources sufficient to initiate and sustain the service; (5) demonstrate the applicant's compliance with the terms and conditions of any previous CONs; and (6) "provide information and analysis" on the "impact of the proposed project on existing health care providers in the service area."

Another Plan standard applied to nursing home reviews is the requirement that every applicant "for a new facility, or for renovation, replacement, or expansion of an existing facility" agree to participate in the Medical Assistance program. This standard was established at a time when numerous nursing facilities did not accept residents who would be Medicaid recipients at admission or would spend down to Medicaid soon after admission. Although it was impossible to mandate these facilities to accept and admit Medicaid recipients, virtually nothing significant that a typical nursing home would seek to undertake – whether expansion, renovation, or a complete replacement facility – could be accomplished without CON approval, which would not happen absent a commitment to admit Medicaid-funded residents. The Plan requires that, as a condition of CON approval for any of the above actions by an existing facility as well as to construct a new facility, each applicant "agree in writing to serve a proportion of Medicaid patients that is at least equal to the proportion of Medicaid patients in all other nursing home beds in the jurisdiction or the health service area, whichever is lower . . . ."[65] This commitment is documented by the submission of a Memorandum of Understanding, executed between the applicant and the Medical Assistance program, which must be provided to the Commission before pre-licensure review. The Plan standard permits a new facility three years to achieve its agreed-upon Medicaid proportion, but requires a showing of "good faith effort" toward that goal during the first two years of operation.

Additional review standards in this section of the State Health Plan require new facilities to be served by a public water system; prohibit a new facility from locating next to an existing facility; present architectural features designed for any "special care needs" among its intended residents; demonstrate "ongoing compliance" with all federal, State, and local safety regulations; and document "awareness of and the ability to meet" all of the "facility and program requirements" found in State licensure regulations. Prospective new nursing homes must also document transfer agreements with other health care facilities to provide any services required by residents that the facility itself cannot provide. Other standards delineate a baseline "appropriate living environment," and require each applicant to agree to organize a "formal grievance procedure, Resident and Family Council, or both" to bring any resident issues to the facility.

In addition to the Certificate of Need review for new or expanded nursing home capacity, owners of existing facilities, or persons who may have purchased the right to operate some number of nursing home beds from an existing or closed must, in most circumstances[66], obtain CON approval to redevelop the existing beds at another site. (Because need for nursing home beds is calculated and projected on the county level, the

[65] COMAR 10.24.08.06A(4).

[66] HB 994 (Ch. 678, Acts 1999) permits a merged asset system to relocate a health care facility (including a nursing home) within that facility's primary service area, as defined in the State Health Plan, through a notice letter to the Commission; the facility may be relocated within the larger primary service area of the entire system, through an exemption finding by the Commission. The capital expenditure necessary to construct the replacement facility would still require CON approval, pursuant to §19-123(k). One provision of HB 994 related to increases or decreases in bed capacity between member hospitals of a merged asset system, also by written notice, expressly excludes nursing home beds from that action. However, merged systems with two or more nursing facilities may reconfigure beds between facilities within the same jurisdiction, with an exemption finding by the Commission.

proposed relocation must be to another site in the same jurisdiction.) An examination of the Commission's Certificate of Need actions over the past three fiscal years shows that relocation of nursing home capacity has become a major activity of the CON program, as it relates to the nursing home industry.

As shown in Table 5 below, the Commission has considered markedly different kinds of CON projects during the last three fiscal years than it typically received and reviewed through the mid-1990s. The Commission's review docket and its monthly report of CON actions (including responses to requests to temporarily delicense nursing home beds, acknowledgements of acquisitions of closed or bankrupt facilities, and of corporate restructuring among nursing home chains) clearly reflect the changed environment and the challenges that confront the nursing home industry, in Maryland as well as across the country.

Table 5 lists all of the CON actions taken by the former HRPC and the Maryland Health Care Commission between July 1, 1997 and June 30, 2000. Five years have passed since the Commission received an application to construct a new facility, implementing new bed need projected by the State Health Plan. The last "new-bed" new facilities approved, as the note to the table indicates, were approved in late 1995 and early 1996, and the 17 beds awarded to Harford Memorial Hospital for its subacute care unit in February 1997 were the last new nursing home beds[67] to come into the system through CON approval.

What has succeeded the traditional new-facility, new-beds CON application are CONs for capital expenditures to replace or renovate existing facilities; applications to relocate existing beds between existing facilities, or from an existing nursing home (or, more commonly, from a facility closed by bankruptcy proceeding) to a new site within the county; and, far more frequently, denials of new CONs and withdrawals of CONs from failed projects. Over the last three fiscal years, actions taken by the Commission include:

- four replacement facilities and major renovation projects;
- a total of eight CON denials, in large comparative reviews in Harford County and on the eastern Shore;
- four extensions of performance requirements for CON projects under development, three of which were eventually relinquished, although the fourth, for an Anne Arundel facility, was built and opened during 1999; and
- one Commission action withdrawing a CON.

[67] As indicated above, beds designated by hospitals or nursing homes as "subacute" are actually licensed by the Department as "special" comprehensive care facility beds.

Table 5
MHRPC/MHCC CON ACTIONS RELATED TO NURSING HOMES, FY 1998-FY 2000

Fiscal Year/Date	Action by Commission
FY 1998	
July 1997	1. Modification approved to CON under development as Lorien-Taneytown, permitting 62 beds to be relocated and developed as Lorien LifeCenter-Mt. Airy, 63 beds as Lorien LifeCenter-Taneytown, with assisted living and shared services (Carroll County). 2. CON applications denied to develop 139 SHP-projected nursing home beds in Eastern Shore Comparative Review. 3. CON applications denied to develop 137 SHP-projected nursing home beds in Harford County Comparative Review.
September 1997	CON for replacement facility approved for Homewood at Crumland Farms (Frederick County).
November 1997	1. Modification approved to CON for Howard County General Hospital subacute care unit (eventually relinquished). 2. CON for replacement facility approved for Brooke Grove Rehabilitation and Nursing Center (Montgomery County).
December 1997	1. Modification approved to CON for Carroll County General Hospital subacute care unit (eventually relinquished). 2. Six-month extension of first performance deadline granted to Upper Marlboro Care Center (Prince George's County0 (eventually relinquished before MHCC withdrawal action).
April 1998	CON to establish 10-bed subacute care unit relinquished by Dorchester General Hospital.
June 1998	Six-month extension to third/final performance deadline for completion of Beechwood LifeCenter (Anne Arundel County).
FY 1999	
September 1998	CON approved to relocate 63 beds from Lorien-Columbia, to establish nursing-home-with-assisted-living model as Lorien LifeCenter-Ellicott City.
October 1998	Exemption from CON granted to close subacute care unit at University Hospital, UMMS.
November 1998	1. CON approved to relocate 40 beds from closed Brevin Nursing Home to establish nursing-home-with-assisted-living model as Lorien LifeCenter-Harford (Harford County). 2. CON approved for $5 million renovation of Collingswood Nursing Center (Montgomery County).
December 1998	CON approved to relocate 70 beds from Riverview Nursing Centre to establish nursing-home-plus-assisted-living model as Lorien LifeCenter-Baltimore County.
April 1999	HRPC upholds its September 1998 withdrawal of non-performing CON held by Willowbrook Nursing Center (Allegany County).
June 1999	Exemption from CON granted to close subacute care unit at Bon Secours Hospital.
FY 2000	
October 1999	CON held by Upper Marlboro Care Center relinquished before MHCC acts on withdrawal recommendation by hearing officer.
April 2000	CON approved to close MedStar's 121-bed Church Nursing Center (Baltimore City).
June 2000	CON approved for $10 million renovation project at Hebrew Home of Greater Washington (Montgomery County).

Source: CON Program Database, Maryland Health Care Commission

Note: The last CONs granted for new nursing home bed capacity were: February 1997: Harford Memorial Hospital, 17-bed subacute care unit; February 1996: Lorien-Taneytown (125-bed facility in Carroll County, modified 7/97 to place 62 beds at a second site in Mt. Airy in southern Carroll County), and Carroll County General Hospital (15-bed subacute care unit-- later relinquished); November 1995**:** Glade Valley Nursing and Rehabilitation Center, Frederick County (124 beds**)**

Hospital subacute units, approved between 1995 and 1997[68], were hard-hit by HCFA's 1998 imposition of a prospective payment system for this Medicare benefit, since it assigned the lowest rates to units not licensed before October 1995. During the last two years, four CONs for hospital-based subacute units have been relinquished (Carroll County General Hospital, Howard County General Hospital, Dorchester General Hospital, and Memorial Hospital of Cumberland) and two that had begun operation were closed by CON exemption (at University of Maryland and Bon Secours Hospitals.)[69]

Four approvals by the Commission – one a modification to an existing CON for 125 new nursing home beds in Carroll County, and three subsequent relocation CONs – signaled a willingness on the part of one nursing home corporation to reshape the traditional facility. Although the approval by the former HRPC of a proposal to split the 125 beds approved for the Lorien-Taneytown facility between the original and a second site in southern Carroll County was contested by an existing facility near the new Mt. Airy site, the HRPC's decision was eventually upheld in the Court of Appeals. In the meantime, the same parent company had brought three additional proposals to the Commission and obtained its approval for a new model of long term facility, with a smaller core of comprehensive care beds (and a still-smaller skilled or subacute-level unit), surrounded by a larger complement of assisted living beds, which are not regulated by CON.

Market Exit: Closures Voluntary and Involuntary

Statute requires that the Commission approve a "change in type or scope" of a health care service provided by a regulated health care facility; although expressed as a double negative, the law requires that before "the elimination of an existing medical service" (which includes "comprehensive [nursing home] care") a health care facility must obtain a Certificate of Need. This may seem counter-intuitive semantically, but what its law requires is that the Commission review the proposed closure of a nursing home. The purpose of this CON review is not to deny permission to close a nursing facility, but to pursue the Commission's "due diligence" in determining the impact on access to these services by the people that depended on the facility, as well as the impact on the remaining facilities in the affected area. In its essence, the review of a CON application to close a facility reverses the process and the questions that shape CON review for new capacity.

The only instance to date of CON review in the voluntary closure of a nursing home is the closure by the MedStar system of the 121-bed Church Nursing Center in Baltimore City, which was located physically within Church Hospital, closed by MedStar

[68] Included in the subacute beds approved during 1995 was a pool of 175 beds established by the former HRPC during deliberations on the Health Care Reform Act of 1995 (Ch. 499, Acts 1995) to respond to the hospital industry's perceived need to establish

[69] The subacute unit at Doctors Community Hospital was temporarily closed for over a year, and Maryland General Hospital's unit remains closed until a decision is reached about its future.

between October and November of 1999.[70] Commission staff focused its review of MedStar's application to close Church Nursing Center on an examination of where and how the patients in the facility were relocated; most were helped by the nursing home staff to find other nearby nursing homes, which increased their occupancies. Staff also examined the origin of Church's patients by zip code, to demonstrate that the facility's service area was well-served by existing, geographically accessible nursing homes. MedStar's analysis of the exigencies of attempting to keep open and operating two floors of a much larger, largely unoccupied building was another factor in the expedited review. Staff issued its report approximately thirty days after the end of the public comment period, and the Commission adopted staff's recommendation on April 20, 2000.

The other closures of nursing homes in Maryland, over the industry's history in the state, have been involuntary: periodic events resulting from bankruptcy proceedings, decertification from Medicaid or Medicare and subsequent closure by the Department for poor quality care, or the occasional instance of an operator's conviction of Medicaid fraud. These closures are generally considered temporary, pending the acquisition of the facility (which requires only a written notice 30 days before completion of the sale, with disclosure of information listed in regulation) and a subsequent proposal for the redevelopment of the beds. In the early- to mid-90s era of high occupancy and a tight market for existing beds, the acquisition of these involuntarily closed facilities and their beds was a foregone conclusion. Five years later, regulations require that beds from CONs withdrawn by the Commission be removed from the inventory.

[70] Church Hospital was the first facility to close under the provisions of 1999's HB 994, which permits hospitals in jurisdictions with three or more hospitals to close after a 45-day written notice to the Commission, if the hospital, in consultation with the Commission, holds a public informational hearing in the affected area.

IV. MARYLAND CERTIFICATE OF NEED REGULATION COMPARED TO OTHER STATES

As it did with home health agency and hospice services, the MHCC commissioned a survey of all fifty states and the District of Columbia, to ascertain the status of Certificate of Need regulation of nursing home beds and facilities across the country, and, if possible, to determine the "principal effects . . . of differing regulatory policies among the states." The complete report based upon this survey by the Commission's contractor, the American health Planning Association, is available as a separate document to accompany this working paper.[71]

A central finding of the study, with regard to the regulation of nursing home beds and facilities by Certificate of Need, is a remarkable degree of consensus – even among states that ended their CON programs over a decade ago – that the supply of nursing home beds needs to be controlled. The mechanisms for limiting growth in capacity vary, but a concern for the impact on each state's Medicaid budget is virtually always the reason, since state Medicaid programs are the primary source of payment for long term nursing care. Figures cited in the AHPA study report for the national expenditures for nursing home care in 1998 show that, of a total outlay of $100 billion, 43% was paid by Medicaid. The next highest payer percentage was private pay, at 31%, followed at a distance by Medicare payments, at 14%, private insurance at 7%, with 5% of the expenditures from other sources.[72]

The AHPA report found the patterns of CON regulation of nursing homes across the states "distinctive," because:

- Fewer states have eliminated or reduced CON regulation of nursing home services than have eliminated or reduced CON regulation of any other service;
- The duration of CON regulation of these services is comparatively long, with many states beginning regulation of this service earlier and retaining it longer than for many other services;
- A surprisingly large number of states have augmented CON regulation of nursing home services with other forms of market entry or capacity management such as moratoria on development; and
- A majority of states that have formally dropped CON regulation have replaced it, at least temporarily, with equally or more stringent market entry and capacity management controls such as development moratoria and reimbursement limits.[73]

The report notes that, with the exception of three western states (Idaho, New Mexico, and Utah), all of the states regulated the development of nursing home beds and

[71] Maryland Health Care Commission, *Certificate of Need Regulation of Nursing Home Services in the United States*, October 25, 2000.
[72] *Id*., citing Feder, J., *et.al.*, "Long Term Care in the United States: An Overview," *Health Affairs* (May/June 2000), p. 43.
[73] *Id.,* p. 10.

facilities for a least a decade over the past 25 years. Initially, the federal health planning requirements mandated CON coverage for nursing home services, but some states had begun ending or at least cutting back their CON programs beginning in the early 1980s. A total of fourteen states have discontinued CON for nursing home services; of these, ten ended their programs between 1983and 1987, when the federal requirement – and funding -- for health planning and CON ended. Of the fourteen states without CON review of nursing homes, six currently have a moratorium in place, and several of the eight currently without a cap on beds or facilities have imposed a moratorium for some period of time in the past. Even though these states ended the limitation on capacity and bar to market entry enforced by the CON requirement, several "effectively replaced [CON] regulation with other market barriers, including moratoria.[74]

Table 7
CON Regulatory Status By State, Nursing Home Services

CON Status	Number of States	Number without Moratorium	Number with Moratorium
CON	37	21	16
No CON	14	8	6
Total*	51	29	22

*Including the District of Columbia

Consequently, while the trend – with regard to CON and most other regulatory tools – has been toward less regulation, and while many of the thirty-seven CON states have removed the CON requirement from some services, the AHPA report shows that "there has been remarkably little actual deregulation of nursing home development." Since, two-thirds of these services are reimbursed by public payers, the concern about the effect of excess capacity on utilization and hence on public program budgets has prompted even CON-free states (primarily in the west and Midwest) to retain some level of capacity control.

With regard to the question of how the CON requirement has restricted the supply of nursing home beds, research from the early 1990s cited in the AHPA report found that "the number of years a state had a CON program and imposed a moratorium on nursing home beds to be negatively correlated" with both the percentage growth in nursing home beds, and a correspondingly positive correlation between average occupancy and the number of years under a CON requirement and moratorium. Other studies from about the same time found that low Medicaid reimbursement rates effectively controlled the supply of nursing home beds. The consensus of the research from that period concluded

[74] Some Western states, such as Arizona, restrict the development of new facilities or capacity seeking reimbursement by the Medicaid program by requiring prior approval by the region's Medicaid managed care organization.

that these two mechanisms – CON and moratoria, and a state's Medicaid payment policies – had the most impact on the supply of nursing home beds.[75]

For more recent years, as occupancies have dropped, the relationships between CON (with or without a moratorium) and nursing home use and occupancy become less clear cut. This is partly because of factors by now familiar: the further development of home care and assisted living alternatives to nursing home placement, the spread of Medicaid waivers for long term care in the community, Medicaid policies that tighten eligibility and limit payment. One trend that does emerge clearly from the data presented in AHPA's report is that "the rate of increase in Medicare- and Medicaid-certified facilities in states that eliminated CON regulation was several times [the rate in] those states that continued CON regulation." [76] Hence, the application of CON and moratoria seems to limit supply of those beds whose creation and use has the greatest impact on public funds.

Another interesting set of comparisons made possible by the data collected in AHPA's survey illustrates that, although quality of care issues have produced legislative remedies now being implemented in Maryland, the State's nursing facilities compare favorably to their counterparts in other states and as a national average. Using data reported by state licensure agencies and on the HCFA website, which compare the average performance on quality surveys by Maryland facilities to that of other CON states, to non-CON states with and without moratoria, and to a national average, Maryland has a much higher percentage of deficiency-free facilities (32%, against 16.3% nationally) and a lower average number of deficiencies (3.1 as compared to 5.4 deficiencies per facility, nationally.)[77]

The report concludes that, despite the elimination of Certificate of Need review in fourteen states, nursing homes remain the health service "most frequently regulated" by CON. From its intensive collection, review, and analysis of data provided by every state on its regulation of nursing home beds and facilities, the AHPA report concludes that "CON regulation of nursing home development . . . appears to be associated with slower capacity growth, higher average occupancy levels, large [and therefore more efficiently-operated] average facility size, lower nursing-home-to-[elderly at-risk]-population bed ratios, and lower age-specific nursing home use rates."[78]

---

[75] The studies cited include Harrington, Curtis, and DuNah's "Trends in State Regulation of the Supply of Long Term Care Services" (HCFA: San Francisco, 1994); Swan, Dewit, *et.al.* "Trends in State Medicaid Reimbursement for Nursing Homes" (HCFA: Witchita University, 1993); and DuNah, Harrington, Bedney, Carillo, "Variations and Trends in State Nursing Facility Capacity, 1987-93" (*Health Care Financing Review*, Fall 1995, p. 184.

[76] Maryland Health Care Commission, *Certificate of Need Regulation of Nursing Home Services in the United States*, October 25, 2000. See Appendix A ,Table A2.

[77] *Id.*, pp. 26-29.

[78] *Id.*, p. 33.

V. ALTERNATIVE REGULATORY STRATEGIES: AN EXAMINATION OF CERTIFICATE OF NEED POLICY OPTIONS

The options discussed in this section represent potential alternative regulatory strategies to achieve the policies, goals, and objectives embodied in Maryland's Certificate of Need program, with regard to oversight of nursing homes. The role of government in these options describes a continuum varying from the current role (Option 1), to a more expanded role on one end of the continuum (Option 2), to an extremely limited role at the other end of the continuum (Option 6). The options discussed below, singly or in combination, suggest potential alternative strategies that could be considered in the context of the larger issue of the regulation of health care services in Maryland. This list of options is by no means an exhaustive one. It is through the public comment process that the Commission expects and encourages other options and ideas to be generated. Another "option" might apply to any of the alternatives for changing the government oversight of nursing homes in Maryland: a change could be phased-in, or approved with a delayed effect to allow for a period of transition. The questions suggested in the guiding principles in the Commission's *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Study Overview* provide a framework for the evaluation of these options.

A. *Option 1 – Maintain Existing Certificate of Need Program Regulation*

This option maintains the Certificate of Need program as currently designed, with the existing coverage and procedural rules. Under current law, as previously described, establishing a new nursing home service requires a Certificate of Need, based on the Commission's review of an applicant's consistency with the State Health Plan policies, standards, need projections, and other CON review criteria. Certain other actions also require CON review and approval, most notably the relocation of existing nursing homes or bed capacity within their jurisdiction, and the capital expenditure (in excess of the current $1.45 million review threshold) needed to replace or do major renovation of an existing nursing home. Voluntarily closing a nursing home also requires Certificate of Need review, which focuses on the impact on patient access and on other facilities in the same area as the facility to be closed.

B. *Option 2 – Expanded Certificate of Need Program Regulation: Include Level 3 and 3+ Assisted Living Facilities*

The question of procedural equity in Maryland between nursing homes and assisted living facilities was raised during the development of regulations governing the establishment and operation of assisted living facilities, in response to 1996 legislation intended to rationalize the patchwork regulation of assisted living programs by several

State agencies.[79] The overall State policy goal of SB 545 was to promote the creation of a more residential, less medical model of long term care, that let individuals "age in place" and receive progressively more complex care as they became medically more fragile, and to reserve more expensive nursing home care (particularly when Medicaid would be the payer) for those needing skilled nursing care.

SB 545 was crafted with a delayed effective date, to give time for the complex process of developing regulations, under the new authority given to the Office of Health Care Quality (then the Licensing and Certification Administration) to license and oversee assisted living facilities. The problem with the "aging in place" model, from the viewpoint of the nursing home industry, was that when assisted living residents eventually needed nursing-home level care, it would be delivered in a bed, and in a facility, not required to undergo CON review and obtain Commission approval, and also not subject to other kinds of regulatory oversight. The prospect of assisted living facilities admitting patients with skilled nursing needs without being subject to a bed need forecast or to CON review was a concern to the nursing home industry. Nursing home representatives argued for the inclusion of provisions that limit the number of skilled-nursing level residents a facility may house at a given time, that require the Office of Health Care Quality to issue a waiver each time a resident must progress to a more complex level of care, and that prohibit assisted living facilities from accepting any person who qualifies for nursing-home level care at the time admission.[80]

The growth and the use by eligible seniors of assisted living facilities has a clear and direct impact on the use of nursing home beds -- in much the same way as the use of adult medical day care, which delays a person's entry into a nursing home, and is factored into the Commission's current bed need methodology. The development of Medicaid waivers to cover assisted living services could broaden this impact on nursing home occupancies across the State. Any factor that further compromises the level of utilization of nursing home beds and facilities intensifies the pressures already besetting this industry.

In response to the effect assisted living has and will to continue to have on nursing homes, nine of the 37 states (including the District of Columbia) that require CON approval for new or expanded nursing facilities also require assisted living facilities to obtain Certificate of Need approval. This option would extend CON review to the bed capacity dedicated to the highest levels of care permitted under assisted living regulations.

[79] Ch. 147, Acts 1996.

[80] In practice, since the January 1, 1999 effective date of the Department's assisted living regulations, OHCQ had received fewer than ten requests for waivers to enable facilities to keep and care for patients who had progressed to Level 3+ or nursing-home level care. Only two had been granted, statewide, by mid-2000.

C. *Option 3 – Impose Moratorium on New Nursing Home Beds*

A significant number of states – among those that continue to require CON approval for nursing homes, as well as those that have ended their CON programs – have imposed a moratorium on new nursing homes and new beds, even on replacement projects, as a way of limiting the impact on their Medical Assistance budgets of nursing home reimbursements.

As shown in the American Health Planning Association's study and survey of how state governments throughout the nation oversee and regulate nursing home capacity and construction, a total of nearly half of the states -- 22 in all -- have imposed a moratorium on new nursing home capacity and projects.[81] Sixteen states that continue to regulate nursing homes through CON have taken this action; six states that have repealed their programs have simultaneously imposed a moratorium on new capacity. The degree of consensus on this one issue is noteworthy: only eight of 50 states (and the District of Columbia) have no barrier to new nursing home capacity through CON or moratorium or both. The fact that state Medicaid reimbursement rates include allowances for capital and operating costs, a lingering concern that a new bed will generate its own demand, and the steady two-thirds of the patient population that spend down to Medicaid within a year of admission – all of these factors continue to provide compelling arguments to the states for controlling nursing home capacity and construction.

The experience of the states that have imposed a moratorium may be instructive, and has been the subject of recent communications between states that retain their CON requirement along with the freeze on capacity, and still require CON review and approval for proposed replacement facilities and major capital renovations by existing facilities. Ohio has had a moratorium on nursing home beds since 1993, and since that year has been "prohibited from calculating a bed need."[82] Although Ohio's average occupancy is "in the 80% range," some "areas and providers with high occupancy could use additional

[81] Once during the history of the former HRPC, the General Assembly imposed a one-year moratorium on that body's action on any proposal related to nursing home beds or facilities. This hiatus in an otherwise vigorous activity was mandated by Ch. 614, Acts 1989, in response to a December 1988 report by a special joint legislative oversight committee, which expressed great concern over the rapidly growing amount of the Medicaid budget dedicated to the "costs and services supported by the program for long term care," and particularly over what was seen as a disproportionate share of those funds devoted to institutional, as opposed to community-based care. The purpose of the moratorium, which extended from June 1, 1989 to June 1, 1990, was to evaluate the effectiveness of the measures by which the HRPC exacted commitments from competing nursing home applicants to also provide community-based services, whether the HRPC's authority to require and enforce these commitments was sufficient, and whether the promised services ever materialized. The report issued after the one-year moratorium recommended ways in which the HRPC could better target and enforce its existing regulatory authority in this regard. It should be observed that much of the "disproportionate" allocation of Medicaid payment between facilities and community-based care was the result of federal-level law and policy; the State's eventual success in obtaining the home- and community-based waiver was a necessary step in seeking to change that balance.

[82] Electronic mail communications from Christine Kenney of Ohio and Thomas Piper of Missouri, through an internet forum established by Piper with the encouragement and support of the American Health Planning Association.

beds." The only source of these beds is the purchase of operating rights to existing beds from existing providers: but the absolute restriction on supply has inflated the purchase price of such beds, and these costs have been passed through to both Medicaid and Medicare. Missouri continues a strict moratorium, but has established a system in which facilities with high occupancy and no deficiencies for 18 consecutive months may seek CON approval to purchase and move beds from anywhere in the state. Many states are re-evaluating their moratorium measures, and the effect that a cap on supply has had on their industries.

One problem with any form of limitation on supply and the potential for "excess demand" – a situation that arguably existed in Maryland through the early and mid-1990s but no longer exists, with occupancy statewide in the 88% range – is that, historically, residents on Medical Assistance or soon to be Medicaid-eligible had the most difficulty in locating a bed. The Commission's requirement that a new, renovating, or expanding facility had to accept Medicaid recipients equal to the jurisdiction's average Medicaid occupancy as a condition for CON approval helped to prevent that circumstance. Concerns for access to nursing home care persist, however, leading 29 states (and the District) to choose against the use of a moratorium to control nursing home bed capacity.

This option does not contemplate a moratorium without a regular, periodic calculation of bed need, in part because of the phenomenon experienced by Ohio, where certain areas and facilities continue to experience high occupancy despite the general downward trend. In addition, though the "baby boom" generation will not use nursing home care in sufficient numbers to ameliorate current low occupancies for some time to come, health care is such a dynamic environment that simple prudence would support continuing to monitor and interpret its changes.

D. *Option 4 – Deregulation of Nursing Homes from Certificate of Need Review, With Creation of a Data Collection and Reporting Model to Encourage Quality of Care*

Another option for nursing home regulation involves replacing the CON program's requirements governing market entry and exit with a program of mandatory data collection and reporting. Some of the same effects that could reasonably be anticipated under deregulation from CON with no alternative, additional means of oversight could also be expected to apply under this option: new supply could enter this already-stressed market with relative ease and rapidity, and further press existing providers. As discussed in Part II, the same 1999 legislation that created a Task Force on Quality of Care in Nursing Facilities in response to concerns about the State's role in monitoring nursing home care also required the Commission to develop a Nursing Home Report Card, in consultation with the Department of Health and Mental Hygiene and the Maryland Department of Aging. As noted in the earlier discussion, the steering committee formed to guide its development has chosen a consulting firm to design a conceptual model of a nursing home report card, and this work continues; 1999's SB 740 requires the Commission to present a preliminary report to the General Assembly on the

development of the nursing home evaluation system by January 1, 2001, with final implementation no later than July 1, 2001.

The "report card" model of performance report is intended to collect and interpret information on how providers rate in those measures of "best practices" chosen as markers of quality, to help guide the decision facing individuals who may require nursing home admission, and their families. Performance reports also provide benchmarks against which providers can measure themselves, and seek to improve quality in any areas found deficient. Consequently, report cards may both inform consumer choice, and also encourage improvement in the performance of nursing home providers. Once the report card is in place, nursing homes might eventually publicize good performance records identified in these regular evaluations, as one HMO has recently begun to do with the release of the Commission's latest HMO Report Card.

Another form that a data reporting and dissemination model of government oversight can take is a "provider feedback" mechanism, targeted more explicitly to informing the providers of care of the areas in which they may be below certain agreed-upon standards of care and efficient operation. It is arguable that such a mechanism already exists for nursing homes, and has far more force than would a gentle suggestion or good example: the Office of Health Care Quality's surveys of nursing homes, whether routine or in response to complaints, result in deficiency findings that operators must address. Failure to respond immediately to identified deficiencies, or to a finding that the extent of a facility's deficiencies has created a situation dangerous to its residents, results in a range of sanctions requiring an immediate plan of correction, and presents the possibility of decertification from Medicaid and Medicare and the end of those payments, and the forced closure of a facility.

E. *Option 5 – Deregulation from Certificate of Need Review, with Approval by Medicaid Program of Any New Nursing Home Beds and Facilities Seeking Medicaid Reimbursement*

Some states that discontinued their Certificate of Need programs in the early 1980s have, in effect, substituted a barrier to market entry for some kinds of nursing facilities – specifically, for any proposed new facility or proposed expansion in bed capacity at an existing facility, where the facility will seek (or already receives) reimbursement from the Medical Assistance program. Since the cost of nursing home capital construction as well as operating costs are factored in to the rates Medical Assistance pays nursing homes to care for its enrollees, the prospective impact on a state's Medicaid budget of new facilities or beds has created wide consensus, in CON and non-CON states, that controlling nursing home capacity is necessary and important.

In Arizona, for example, health services for all Medicaid recipients are managed care, controlled by HMOs. A regional HMO has the authority to reject applications by proposed new facilities, whether hospitals or nursing homes, to become new Medicaid

providers.[83] To the extent that a proposed new nursing home would depend on payments by Medical Assistance to support its patient base, its operations, and its initial construction, this mechanism could present a considerable barrier to entry into what is an already challenged market. Under this option, while the Medical Assistance program could assume the responsibility for conducting reviews for proposed new Medicaid providers, the need for objective standards by which to conduct such reviews – and the expertise in conducting quantitative analysis of the need for a new facility or bed capacity – would suggest that the Commission would continue as the reviewing authority, at least initially.

F. *Option 6 – Deregulation of Nursing Homes From Certificate of Need*

This option would remove Certificate of Need review and approval, and the barrier to market entry or exit. It would defer to the authority and rules of the State health department and its licensing agency, and particularly to those rules and conditions of participation in both Medicare and Medicaid that OHCQ administers on behalf of the federal government. Capacity of beds and facilities would not be limited by the demographically-and geographically-based formula of the Commission's bed need projections, nor subjected to the initial review of program, staffing levels, and reasonableness of construction costs that comprises much of the focus of CON review.

The array of environmental factors that present challenges to the nursing home industry – the growth of assisted living and other alternative sites, the clinical and technological advances in home care capabilities, changes in Medicare reimbursement, the improved health status of older Americans – have reduced the incentive to build new nursing homes. Neither private lenders nor the federal Department of Housing and Urban Development are currently lending money or arranging mortgage loans for long term care projects. The bankruptcies and reorganizations previously described further document these difficulties.

This fact, with the other problems facing nursing homes – including the general, serious shortages of nurses and other health care professionals at a time when quality legislation mandates higher staffing ratios and nursing hours -- might argue that no untoward impact will result if nursing homes are relieved of the statute's CON requirement. This view would cite the immense challenges facing the present providers as sufficient to discourage new providers, or those from out of state. An alternative view would suggest that when the volatile health care environment changes, there could be a push for overbuilding in the absence of CON, when market forces change. The Commission can decide to periodically re-evaluate any or all of its various roles in the regulatory oversight of nursing homes in Maryland – in limiting new capacity through CON review, in planning, in projecting future need, in collecting data and issuing report

[83] Conversations with Paul Schafer of the Arizona office of Health Cost Control, mid-October 2000. Mr. Schafer noted that Medicaid HMOs in both the Tucson and the Phoenix area had recently denied new-provider requests by nursing homes.

cards – or it can decide to recommend that the General Assembly consider one of these alternative options (or a hybrid of these or additional options) for future implementation.

V. SUMMARY

This report examines a range of current policy and regulatory issues affecting nursing homes, and outlines several alternative policy options for changes to the role of Certificate of Need in the regulation of nursing homes in Maryland, and some potential implications of those changes. Table 7 below summarizes the policy options discussed in this paper. The Commission expects that the public comment received on this options paper will identify additional policy options and approaches that also merit consideration, and is particularly interested in receiving comments on the financial impact that would result from changes to CON regulation of this service.

Table 7
Summary of Regulatory Options

Options	Level of Government Oversight	Description	Administrative Tool
Option 1 Maintain Existing CON Regulation	No Change in Government Oversight	Market entry and exit regulated by CON	Commission Decision (Certificate of Need)
Option 2 Expanded CON Regulation: Include Level 3, 3+Assisted Living Facilities	Increase Government Oversight	Market entry and exit regulated by CON for both nursing homes and assisted living facilities	Commission Decision (Certificate of Need)
Option 3 Impose Moratorium on New Nursing Home Beds	Change Government Oversight	Market entry barred; Changes to existing capacity and market exit through CON Review	Commission Decision (Certificate of Need)
Option 4 Deregulation of Nursing Homes from CON Review, Reliance on Data Reporting Model	Change Government Oversight	No barrier to market entry or exit by CON review	Performance Reports/Report Cards
Option 5 Deregulation from CON Review, Approval by Medicaid of New Certified Nursing Home Beds or Facilities	Change Government Oversight	Control of market entry for new Medicaid-certified beds, facilities	DHMH review and approval for new beds or facilities seeking Medicaid payment, based on Medical Assistance budget
Option 6 Deregulation of Nursing Homes from CON Review	Decrease Government Oversight	No control of market entry or exit by CON review	Compliance with State licensure and Medicare, Medicaid certification standards

Appendix A

Maryland and Federal Long Term Care Policy Initiatives 1965-2000

MARYLAND FEDERAL LONG TERM CARE POLICY INITIATIVES: 1965-2000*

* Items in regular print are federal initiatives; *items in Italics are state programs*

1965-1969

- Medicare, Medicaid, and Older Americans Act enacted by the U.S. Congress
- *Nursing Home Regulations implemented in Maryland*
- *Maryland's Comprehensive Health Planning Agency established*
- *Geriatric Evaluation Services (GES) established in Maryland*

1970-1979

- *Certificate of Need (CON) process established in Maryland*
- *Adult Day Care Division in DHMH authorized*
- *Community Home Care Services established by the General Assembly*
- Social Services Block Grants established by the U.S. Congress
- *Maryland Nutrition Program for the elderly established*
- *Maryland Office on Aging established*
- *Sheltered Housing Program began*
- *Project HOME began in the Department of Human Resources*
- *Deinstitutionalization of patients from State mental hospitals mandated by the General Assembly*
- The Ombudsman Program created under the Older Americans Act
- *First State Health Plan section on Long Term Care developed*

1980-1989

- *Medical Day Care began in Maryland*
- *Maryland Medicaid Personal Care Program begun*
- *Statewide Respite Care Program for persons with developmental disabilities established*
- Institute of Medicine conducted a study of nursing home regulations and reported prevalent problems regarding the quality of care and need for stronger federal regulations
- GAO reported that over one third of nursing homes are operating below federal minimum standards. This led to the passage of the Omnibus Budget Reconciliation Act (OBRA of 1987).
- Part of OBRA 1987 was the Comprehensive Nursing Home Reform Act (PL100-203) which included the development of the minimum data set (MDS)
- *Maryland one of ten sites for* National Long Term Care Channeling Demonstration

- *Interagency Committee on Aging Services established*
- *Maryland Health Resources Planning Commission established*
- *Maryland Medicaid nursing home case mix reimbursement system initiated*
- *Biannual Maryland Long Term Care Survey initiated*
- Gateway II established *in Maryland*
- *Governor's Task Force on Alzheimer's Disease and Related Disorders convened*
- *Developmental Disabilities Home and Community-Based Waiver received*
- *Domiciliary Care Facilities Board created*
- *Governor's Task Force on Elder Abuse and Neglect convened*
- *Project HOME expanded eligible population, changed name to C.A.R.E. Program*
- *Statewide Evaluation and Planning Services (STEPS) established (pre-admission screening program)*
- *Governor's Housing Initiative*
- *Statewide Specialized Transportation Program (SSTAP) established*
- *Maryland Medicaid Home Care for Technology Assisted Children waiver in effect*
- *Respite Care for Functionally Disabled Adults enacted by General Assembly*
- *Pre-admission Screening and Annual Resident Review (PASSAR) begun*
- *State Health Plan sections developed on: Institutional Long Term Care; Residential Long Term Care; Community-Based Services; Hospice; Home Health; Life Care Services*

1990-2000

- HCFA's OSCAR (Online Survey Certification and Reporting System) came online.
- The Nursing Home Reform act led to new enforcement provisions outlined in the State Operations Manual (SOM) in 1995. A new HCFA certification process also began in 1995. The Ombudsman Program developed NORS (National Ombudsman Reporting System) in 1995
- Balanced Budget Act (BBA) passes, changing payment for nursing home and home health care to prospective payment system
- Balanced Budget Refinement Act passes, making some changes to the impact of the BBA
- *Rehabilitation Organization and Management Panel issued report*
- *Governor's Task Force on Services to the Elderly convened*
- *Final Report of the Long Term Care Committee of the Governor's Commission on Health Care Policy and Financing Issues*
- *MHRPC changes Maryland Long Term Care Survey to an annual survey*
- *1915c waiver approved using Senior Assisted Housing*
- *State Health Plan section developed that integrates all Long Term Care Services, both institutional and community-based, into a single plan section*
- *Nursing home bed need methodology developed that reduces nursing home bed need projections by substituting adult day care for certain light care residents*

- *DHMH/Milbank Memorial Fund Long Term Care Retreat held*
- *Maryland Health Care Decisions Act enacted by General Assembly*
- *Governor's Task Force on Assisted Living-legislation enacted, regulations developed*
- *Long Term Managed Care Advisory Committee convened*
- In March, 1999 both OIG and GAO release studies on the quality of care in nursing homes, making recommendations to change the survey and certification process. The GAO Report severely criticized Maryland's regulatory oversight of the nursing home industry
- *Task Force on Quality of Care in Nursing Facilities. The group made recommendations, seven bills were introduced during the 2000 session of the General Assembly, and six were passed*
- *Maryland Health Care Commission begins work on development of nursing home report cards*
- *October, 1999 the Maryland Health Care Commission was formed by the merger of the Maryland Health Care Access and Cost Commission and the Maryland Health Resources Planning Commission*
- *Medicaid applied to HCFA for, and obtained, a waiver to cover assisted living services.*

Source: Maryland Health Care Commission, *Environmental Assessment: Nursing Home Industry Issues and Trends.* July 2000

Appendix B

Summary of Provisions of Nursing Home Quality Initiatives
2000 Legislative Session

- **HB 784/SB794 Staffing**: $40 million added to the Medicaid budget over the next two years to support increased staffing in nursing homes. The funding increase is to enable nursing homes to :

  Increase the hours of direct care to residents;
  Increase their nursing staff; and
  Increase wages, fringe benefits, and other forms of compensation to direct care personnel.

  Funds will be provided through increased payments in the Nursing Service Cost Center of the Medicaid reimbursement formula.

  The additional funds may not be used to provide an increase in the profit allowed in the Nursing Service Cost Center.

  This measure requires the Department of Health and Mental Hygiene to reconvene the Medicaid Nursing Home Reimbursement Study Group to review the existing reimbursement formula and the proposed funding appropriation for FY02 and FY03 and report its findings to the Senate Finance and House Environmental Matters Committees on or before December 1, 2000.

  A provision increasing staffing requirements to 4.0 nursing hours per day was defeated.

- **HB 747/SB690 The Maryland Nursing Home Quality Assurance Act**: This measure requires nursing homes to do the following:

  Designate by September 1, 2000 a qualified individual to coordinate and manage the nursing home's quality assurance program;

  Establish a Quality Assurance Committee;

  Establish a written quality assurance plan;

  Employ a medical director responsible for monitoring physician services who shall report monthly to the quality assurance committee on the quality of the medical care at the nursing home;

  Establish a procedure to provide for the transfer of patients in the event of closure;

  Provide notice to residents and their families or guardians when the nursing home learns of probable closure or loss of public funding;

  Notify the resident's representative or guardian of any injury; and

Post their staffing ratios (licensed staff to residents and unlicensed staff to residents) in a visible location on each floor.

Each quality assurance plan must include procedures for concurrent review for all residents, criteria for review of certain categories of care and specific incident reports, and methods to identify and correct problems. This plan must be available to residents and be submitted to DHMH by January 1, 2001. Additionally, each nursing home's quality assurance committee must be comprised of certain members, meet monthly, maintain records of all quality assurance activities, keep records of committee meetings that must be available to DHMH during any on-site visit; and review and approve the home's annual quality assurance plan. Moreover, the nursing home administrator must take appropriate remedial actions based on the recommendations of the committee.

- **HB 634/SB689 Sanctions and Penalties**: Provides the Department of Health and Mental Hygiene (DHMH) with the authority to impose sanctions and penalties instead of federal sanctions and penalties including civil money penalties against nursing homes when a deficiency or an ongoing pattern of deficiencies exists.

This measure specifies that penalties for potential harm deficiencies may not exceed $10,000 per instance or $1,000 per day until the nursing home is in compliance. Penalties for actual harm deficiencies may not exceed $10,000 per instance or $10,000 per day until the nursing home is in compliance. Calculation of the amount of the civil penalty will stop when DHMH verifies corrective action and sustained compliance on the part of the nursing home.

If the nursing home appeals a civil money penalty, the funds are to be deposited in an interest bearing escrow account at the nursing home's expense. If the penalty is upheld, the monies must be released to DHMH within 15 days from the date of the decision. If the penalty is reversed, the funds held in escrow will be released to the nursing home within 15 days from the date of the decision. Funds retained by DHMH must be sued for training, grant awards, demonstration projects, or programs designed to improve quality of care.

This was emergency legislation and took effect from the date it was enacted during the 2000 legislative session.

- **HB 748/SB 688**: Requires DHMH to conduct an unannounced site visit and a full survey of each licensed nursing home twice each calendar year. If, in the two most recent surveys of the nursing home conducted after October 1, 2000, the nursing home has had no deficiencies that have the potential for minimum harm or greater, DHMH may waive the second annual survey.

- **HB 748/ SB 698 Quality of Care Oversight**: Continues the Nursing Home Task Force as an oversight body.

  This measure creates an Oversight Committee on Quality of Care in Nursing Homes to monitor and evaluate implementation of the recommendations of the Task Force on Quality of Care in Nursing Facilities and to evaluate the progress in improving nursing home care quality, including:

  - quality of care standards for nursing homes;
  - staffing patterns and staffing standards;
  - policies for inspecting nursing homes and responding to complaints;
  - a comparison of Maryland policies to those in other states;
  - a labor pool available to fill nursing and nursing aide jobs;
  - State funding mechanisms; and
  - the regulation of nursing homes.

  This legislation requires the Office of Health Care Quality ("OHCQ") to submit a report to the Oversight Committee on March 1 and September 1 of each year on the implementation of the Task Force on Quality of Care in Nursing Facilities's recommendations and the status of quality of care in nursing homes. The Oversight Committee is to review these reports, develop recommendations to continue improvement in nursing home care, and report its recommendations to the Governor and the General Assembly on or before December 1 of each year. The bills sunset on December 31, 2005.

- **HB 865 Ombudsman Program**: Required the Secretary of the Department of Health and Mental Hygiene to establish and submit a budget for minimum staffing ratios for the Ombudsman Program at the higher of one full-time ombudsman per 1,000 long term care beds, 20 hours of ombudsman time per week per Area Agency on Aging, or 10 hours of ombudsman time per week per nursing home. To fund this measure expanding the Ombudsman Program, the legislature approved a budget increase of an additional $1.9 million over the next three years.

In addition, SB 435, which would have created an awards program for nursing assistants financed by charging $750 for follow-up inspection visits, was defeated.

Appendix C

MHCC Inventory of Comprehensive Care Beds – October 2000

MHCC INVENTORY of COMPREHENSIVE CARE BEDS - October 17, 2000

Maryland State Summary

LHPA County Facility name	Licensed Beds	Certified Beds	Waiver Beds	Temp Delic Beds	Total Beds
Western Maryland					
Allegany County	931	0	19	0	950
Carroll County	822	123	10	10	955
Frederick County	1140	1	0	23	1141
Garrett County	344	0	0	21	344
Washington County	1293	0	6	70	1299
Western Maryland	4530	124	35	124	4689
Montgomery County					
Montgomery County	4826	8	90	76	4916
Montgomery County	4826	8	90	76	4916
Southern Maryland					
Calvert County	294	0	2	0	296
Charles County	377	0	0	0	377
Prince George's County	2969	0	21	63	2990
St. Mary's County	337	0	0	20	337
Southern Maryland	3977	0	23	83	4000
Central Maryland					
Anne Arundel County	1837	0	60	114	1897
Baltimore County	5996	94	162	322	6377
Harford County	657	40	14	16	711
Howard County	537	50	10	0	597
Baltimore City	5552	191	87	870	6389
Central Maryland	14579	375	333	1322	15971
Eastern Shore					
Caroline County	237	0	0	5	237
Cecil County	446	9	10	0	465
Dorchester County	313	0	0	4	313
Kent County	206	0	0	0	206
Queen Anne's County	180	0	0	18	180
Somerset County	210	0	3	0	213
Talbot County	358	0	0	8	358

Maryland State Summary

LHPA County Facility name	Licensed Beds	Certified Beds	Waiver Beds	Temp Delic Beds	Total Beds
Wicomico County	742	0	0	40	742
Worcester County	400	2	0	12	402
Eastern Shore	3092	11	13	87	3116
MARYLAND STATE TOTAL	31004	518	494	1692	32692

Appendix D

Licensed Assisted Living Facilities by Jurisdiction: Maryland

Table D-1
Licensed Assisted Living Facilities
by Jurisdiction: Maryland, 2000

County	Number of Licensed Facilities	Number of Beds
Allegany	12	195
Anne Arundel	103	1,297
Baltimore City	563	2,654
Baltimore County	247	2,951
Calvert County	12	126
Caroline County	17	103
Carroll County	42	653
Cecil County	26	218
Charles County	26	223
Dorchester County	21	71
Frederick County	17	520
Garrett County	9	53
Harford County	50	528
Howard County	93	1,370
Kent County	14	71
Montgomery County	139	2,868
Prince George's County	199	1,466
Queen Anne's County	14	78
St. Mary's County	5	237
Somerset County	1	5
Talbot County	5	92
Washington County	27	769
Wicomico County	13	317
Worcester County	7	47
Total All Jurisdictions[84]	1,662	16,912

[84] Source: Maryland Department of Health and Mental Hygiene, Office of Health Care Quality, Count of Assisted Living Beds by County, October 11, 2000.

Appendix E

State Health Plan Nursing Home Bed Need Methodology

Nursing Home Bed Need Methodology

The current nursing home bed need methodology is used to project future need for nursing home beds. It uses past patterns of age-adjusted utilization and projects them forward, with adjustments for migration, and utilization of community-based services. The current methodology can be described by the following steps:

1. Calculate the base year (1997) patient days, by age group (<65, 65-74, 75-84, 85+), area of origin, and jurisdiction of care.
2. Calculate the average use rate for each Maryland jurisdiction for each age group.
3. Calculate the target year (2004) patient days for each age group for each Maryland jurisdiction of residence by multiplying the average use rate for a given age group in the jurisdiction of residence by the target year projected population for the same age group in the jurisdiction, and dividing the result by 1000.
4. Calculate the target year patient days for each group for each jurisdiction of care, according to the following assumptions:

    - The need projection for nursing home beds reduces net out-migration from each area of origin by half and allocates the reduction back to the area of origin.
    - Migration into Maryland from the adjacent sates of Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia is taken into account in estimating bed need, by assuming that the current pattern of migration from these adjacent states into Maryland will increase in the future at their projected rate of population growth.
    - Migration into Maryland from other than adjacent states is not taken into account in estimating need.
    - Out-migration from Maryland to adjacent and other states is assumed to remain constant.

5. Calculate the target year patient days for each jurisdiction of care by summing the target year patient days for each age group in the jurisdiction of care over all age groups.
6. Calculate the gross bed need for each jurisdiction of care by dividing the target patient days for the jurisdiction by the product of 365 and 0.95.
7. Calculate the net need for each jurisdiction of care by subtracting the inventory of beds from the gross bed need for the jurisdiction.
8. Calculate the number of nursing home beds for which adult day care slots will substitute in each jurisdiction of care by multiplying together the number of nursing home patient days appropriate for adult day care, by area of origin, the participation rate in adult day care by persons who would otherwise use nursing homes, and dividing the result by the product of 365 and 0.95.

9. Calculate the adjusted bed need for each jurisdiction of care by subtracting the number of nursing home beds for which adult day care slots will substitute from the net bed need for each jurisdiction of care.